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Part 1

MEDICARE AND MEDICAID BUDGET RECONCILIATION AMENDMENTS OF 1983

OCTOBER 26, 1983.—Ordered to be printed

Mr. DINGELL, from the committee on Energy and Commerce, submitted the following

REPORT

together with

SUPPLEMENTAL AND MINORITY VIEWS

[To accompany H.R. 4136 which on October 6, 1983, was referred jointly to the Committee on Energy and Commerce and the Committee on Ways and Means]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4136) to amend title XVIII of the Social Security Act to provide for reconciliation savings and other changes with respect to the medicare program, to amend title XIX of such act to increase the Federal medical assistance matching percentage for services provided to certain pregnant women and young children under State medicaid plans, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

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SECTION 1. This Act may be cited as the "Medicare and Medicaid Budget Reconciliation Amendments of 1983".

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TITLE I—MEDICARE RECONCILIATION AMENDMENTS

PART A—PAYMENT- AND COVERAGE-RELATED CHANGES

PAYMENT FOR OUTPATIENT DIAGNOSTIC LABORATORY TESTS

SEC. 101. (a) Subsection (a) of section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

(1) by amending clause (D) of subsection (a)(1) to read as follows: "(D) with respect to diagnostic laboratory tests for which payment is made under this part, the amounts paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii) or under the procedure described in section 1870(f)(1)) of the lesser of (i) the amount de-

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termined under subsection (h), or (ii) the amount of the charges billed for the tests,";

(2) by inserting "or (D)" in paragraph (2)(B) after "subparagraph (C)";

(3) by striking out "and" at the end of paragraph (2)(B);

(4) by inserting "and" at the end of paragraph (2)(C); and

(5) by adding at the end of paragraph (2) the following new subparagraph:

"(D) with respect to diagnostic laboratory tests for which payment is made under this part, 100 percent of the lesser of (i) the amount determined under subsection (h), or (ii) the amount of the charges billed for the tests;".

(b) Subsection (b) of such section is amended—

(1) by striking out "and" at the end of clause (2) of subsection (b); and

(2) by inserting before the period at the end of the first sentence of subsection (b) the following: ", and (4) such deductible shall not apply with respect to diagnostic laboratory tests for which payment is made under this part on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider of services with an agreement in effect under section 1866.".

(c) Subsection (h) of such section is amended to read as follows:

"(h)(1) The Secretary shall establish in accordance with this subsection a national fee schedule for diagnostic laboratory tests for which payment is made under this part.

"(2) Except as provided in paragraph (4), the Secretary shall set the fee schedule at 60 percent of the prevailing charges paid under this part for similar diagnostic laboratory tests during the fee screen year beginning July 1, 1983, adjusted annually to reflect changes in the Consumer Price Index for All Urban Consumers (U.S. city average) and subject to such other adjustments as the Secretary determines are justified by technological changes.

"(3) In addition to the amounts provided under the fee schedule, the Secretary shall provide for and establish a nominal fee to cover the costs in collecting the sample on a diagnostic laboratory test that was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter.

"(4)(A) During the 3-year period beginning March 1, 1984, the Secretary may provide for the fee schedule under this subsection to be established on a regional or statewide basis if the Secretary determines that a national fee schedule is inappropriate at such time because of limitations in the data available to establish such a schedule.

"(B) In establishing a fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

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"(5) In the case of a bill or request for payment for a diagnostic laboratory test for which payment may otherwise be made under this part—

"(A) no payment may be made under this part to a physician with respect to such test unless the physician (or another physician with whom the physician shares his practice) personally performed or supervised the performance of the test, and

"(B) payment for such a test performed by a laboratory which is independent of a physician's office or a rural health clinic may only be made on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider of services with an agreement in effect under section 1866.".

(d) Section 1842(h) of such Act (42 U.S.C. 1395u(h)) is repealed.

(e) The last sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting "and with respect to diagnostic laboratory tests" after "section 1861(s)(10)".

(f)(1) Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(A) by inserting "and" at the end of paragraph (42);

(B) by striking out paragraph (43); and

(C) by redesignating paragraph (44) as paragraph (43).

(2) Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended—

(A) by striking out the period at the end of paragraph (6) and inserting in lieu thereof "; or", and

(B) by adding after paragraph (6) the following new paragraph:

"(7) with respect to any amount expended for diagnostic laboratory tests performed by a physician, independent laboratory, or hospital (other than for an inpatient of the hospital), to the extent such amount exceeds the amount payable under section 1833(h) for such tests.".

(g) The Secretary of Health and Human Services (hereinafter in this title referred to as the "Secretary") shall simplify the procedures under section 1842 of the Social Security Act with respect to claims and payments for diagnostic laboratory tests under part B of title XVIII of such Act.

(h)(1) Except as provided in paragraph (2), the amendments and repeal made by this section shall apply to diagnostic laboratory tests furnished on or after March 1, 1984.

(2) The amendments made by subsection (f)(2) shall apply to payments for calendar quarters beginning on or after April 1, 1984.

COVERAGE OF ADMINISTRATION OF HEPATITIS B VACCINE

SEC. 102. (a) Section 1861(s)(10) of the Social Security Act (42 U.S.C. 1395x(s)(10)) is amended—

(1) by inserting "(A)" after "(10)",

(2) by striking out the period at the end and inserting in lieu thereof "; and", and

(3) by adding at the end the following new subparagraph:

"(B) hepatitis B vaccine and its administration, furnished in a hospital or a renal dialysis facility.".

(b) Section 1833 of such Act (42 U.S.C. 1395*l*) is amended by adding at the end the following new subsection:

"(k) With respect to services described in section 1861(s)(10)(B), the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.".

(c) The amendments made by this section apply to services furnished on or after January 1, 1984.

PART B PAYMENT FOR SERVICES OF TEACHING PHYSICIANS

SEC. 103. (a) Section 1842(b)(6)(B) of the Social Security Act (42 U.S.C. 1395u(b)(6)(B)) is amended—

(1) by striking out "physician who has a substantial practice outside the teaching setting" in clause (i) and inserting in lieu thereof "physician who is not a teaching physician (as defined by the Secretary)";

(2) by striking out "outside practice" in clause (i) and inserting in lieu thereof "practice outside the teaching setting";

(3) by striking out "In the case of a physician who does not have a practice described in clause (i)" in clause (ii) and inserting in lieu thereof "Except as provided under clause (iii), in the case of a teaching physician";

(4) by striking out "greater" in clause (ii) and inserting in lieu thereof "greatest";

(5) by striking out "or" at the end of subclause (I) of clause (ii);

(6) by striking out the period at the end of subclause (II) of clause (ii) and inserting in lieu thereof ", or";

(7) by adding at the end of clause (ii) the following new subclause:

"(III) 75 percent of the prevailing charges paid for similar services in the same locality."; and

(8) by adding at the end thereof the following new clause:

"(iii) If all the teaching physicians in the hospital agree to have payment made for all physicians' services under this part furnished patients in the hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1870(f)(1), the carrier shall take into account the amounts otherwise payable under this part with respect to similar services in the same locality.".

(b) The amendments made by subsection (a) shall apply to services furnished on or after July 1, 1984.

INFORMATION ON PHYSICIAN ASSIGNMENT PRACTICES

SEC. 104. Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsections:

"(i)(1) The Secretary shall compile annually a list of physicians serving individuals enrolled under this part indicating the share (by percentile intervals not to exceed quartiles) of claims which each physician has accepted on an assignment basis (described in subsection (b)(3)(B)(ii)) or has had payment made under the procedure described in section 1870(f)(1) in the preceding year.

"(2) The Secretary shall make available in each office of the Social Security Administration the information compiled under

paragraph (1) for the local geographic area served by the office no more than six months after the end of each year and, upon request, by mail from each carrier. The Secretary shall, when such information becomes available, annually notify each individual enrolled under this part of the availability of such information.

"(j)(1) The Secretary shall publish annually a list of all physicians who have agreed in accordance with this subsection to accept payment under this part on the basis of an assignment (described in subsection (b)(3)(B)(ii)) or under the procedure described in section 1870(f)(1) for all services furnished under this part during the following twelve-month period to individuals enrolled under this part.

"(2) To permit the publishing of the list provided under paragraph (1), the Secretary shall annually, before the beginning of the twelve-month period, offer physicians a reasonable opportunity to sign an agreement that they will accept payment under this part on the basis of an assignment (described in subsection (b)(3)(B)(ii)) or under the procedure described in section 1870(f)(1) for all services furnished under this part during the following twelve-month period to individuals enrolled under this part.

"(3) The Secretary shall annually provide to each individual enrolled under this part and residing in a local geographic area notice of the availability of the list of all physicians in that area who have signed such an agreement for the following twelve-month period.".

STUDY OF MEDICARE PART B PAYMENTS

SEC. 105. (a)(1) The Secretary of Health and Human Services shall study and report to Congress, no later than December 30, 1984, on methods by which payment amounts and other program policies under part B of title XVIII of the Social Security Act may be modified—

(A) to eliminate inequities in the relative amounts paid to physicians by type of service, locality, and specialty, with particular attention to any inequities between cognitive services and medical procedures;

(B) to increase incentives for physicians and other suppliers under such part to accept assignment for medicare services; and

(C) to provide incentives for physicians and other providers not to provide increased or otherwise excessive amounts of hospital, physician, and other health care services.

(2) In carrying out the study under paragraph (1)(A), the Secretary shall take into account the relative time, complexity, investment in professional training, and overhead expenses necessary to the provision of various medical services and procedures.

(3) The report of the Secretary shall include a description of one or more national or regional fee schedules for payments under part B of title XVIII of the Social Security Act which are consistent with the findings of the study under this subsection.

(b) In order to carry out the study and facilitate Congressional review, the Secretary shall compile a centralized medicare part B charge data base, utilizing information gathered by the medicare

carriers and used by them in making the 1984 reasonable charge updates. Such data shall include information, by procedure, on—

(1) utilization,

(2) assignment rates of physicians and suppliers,

(3) actual, customary, and prevailing charges, and

(4) the differences in charges by physician specialty and locality.

(c) The report of the Secretary shall include recommendations for legislative amendments necessary to implement the findings and recommendations of the study under this section.

(d) In preparing the report and recommendations, the Secretary shall consult, as appropriate, with national organizations of physicians and other interested associations and individuals.

PACEMAKER REIMBURSEMENT REVIEW AND REFORM

SEC. 106. (a)(1) The Secretary shall issue revisions to the current guidelines for the payment under part B of title XVIII of the Social Security Act for the transtelephonic monitoring of cardiac pacemakers. Such revised guidelines shall include provisions regarding the specifications for and frequency of transtelephonic monitoring procedures which will be found to be reasonable and necessary.

(2)(A) Except as provided in subparagraph (B), if the guidelines required by paragraph (1) have not been issued and put into effect by February 1, 1984, payment may not be made under part B of title XVIII of the Social Security Act for transtelephonic monitoring procedures (with respect to a single-chamber cardiac pacemaker powered by lithium batteries) conducted more frequently than—

(i) weekly during the first month after implantation,

(ii) once every two months during the period representing 80 percent of the estimated life of the implanted device, and

(iii) monthly thereafter.

(B) Subparagraph (A) shall only apply to the monitoring of single-chamber cardiac pacemaker devices powered by lithium batteries, and shall not apply in cases where the Secretary (or the Secretary's agent) determines that special medical factors (including possible evidence of pacemaker malfunction) justify more frequent transtelephonic monitoring procedures.

(b)(1) The Secretary shall review, and report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate, regarding the appropriateness of the current rate of reimbursement under part B of title XVIII of the Social Security Act for physicians' services associated with implantation or replacement of pacemaker devices and pacemaker leads. Such review shall take into account the amounts recognized as reasonable with respect to such procedures and the time and difficulty of such procedures at the current time in comparison with such amounts and the time and difficulty of such procedures at the time the rates for such procedures were first established under such part. In making such review and report, the Secretary shall take into consideration the reduction of such recognized rates by 20 percent.

(2) The Secretary shall complete the review described in this subsection not later than April 1, 1984.

(c) Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end thereof the following new subsection:

"(g)(1) The Secretary shall, through the Commissioner of the Food and Drug Administration, provide for a registry of all cardiac pacemaker devices and pacemaker leads for which payment was made under this title. Such registry shall include the manufacturer, model, serial number, and manufacturer's price of each such device or lead, the name of the recipient of such device or lead, the date and location of the implantation or removal of the device or lead, the name of the physician involved in implanting or removing such device or lead, the name of the hospital or other provider billing for such procedure, any express or implied warranties associated with such device or lead under contract or State law, and such other information as the Secretary deems to be appropriate. Such registry shall be for the purposes of assisting the Secretary in determining when payments may properly be made under this title, determining when inspection by the Food and Drug Administration may be necessary under paragraph (2), and carrying out studies with respect to the use of such devices and leads. In carrying out any such study, the Secretary may not reveal any specific information which identifies any pacemaker device or lead recipient by name (or which would otherwise identify a specific recipient). Any person or organization may provide information to the registry with respect to cardiac pacemaker devices and leads other than those for which payment is made under this title.

"(2) In any case where the Secretary has reason to believe, based upon information in the pacemaker registry or otherwise available to him, that replacement of a cardiac pacemaker device or lead for which payment is or may be requested under this title is related to the malfunction of a device or lead, the Secretary may require that personnel of the Food and Drug Administration test such device, or be present at the testing of such device by the manufacturer, to determine whether such device was functioning properly.".

PAYMENT FOR DEBRIDEMENT OF MYCOTIC TOENAILS

SEC. 107. The Secretary shall provide, pursuant to section 1862(a) of the Social Security Act, that payment will not be made under part B of title XVIII of such Act for a physician's debridement of mycotic toenails to the extent such debridement is performed for a patient more frequently than once every 60 days, unless the medical necessity for more frequent treatment is documented by the billing physician.

PART B—MISCELLANEOUS ADMINISTRATIVE CHANGES

REPEAL OF SPECIAL TUBERCULOSIS TREATMENT REQUIREMENTS AND REQUIREMENT OF ACCREDITATION FOR PSYCHIATRIC HOSPITALS

SEC. 111. (a) Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(1) by striking out subparagraph (B) of paragraph (2),

(2) by striking out "and inpatient tuberculosis hospital services" in paragraph (3),

(3) by striking out paragraph (5), and

(4) by striking out "(B)," in the sentence that follows paragraph (8).

(b) Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(1) by striking out subsections (d) and (g),

(2)(A) by inserting "and" at the end of paragraph (3) of subsection (f),

(B) by striking out "; and" at the end of subsection (f)(4) and inserting in lieu thereof a period,

(C) by striking out paragraph (5) of subsection (f), and

(D) by striking out "if the institution is accredited" and all that follows through "Secretary" in the second sentence of subsection (f);

(3) by striking out "or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or" in the fifth sentence of subsection (e), and

(4) by striking out "or tuberculosis" in the first sentence of subsection (j) that follows paragraph (15).

(c) Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking out "(g)(4),".

(d) Section 1866 of such Act (42 U.S.C. 1395cc) is amended—

(1) by striking out "tuberculosis hospital services and" in subsection (b)(3), and

(2) by striking out "inpatient tuberculosis hospital services and" in subsection (d).

(e) Section 1902(a)(28) of such Act (42 U.S.C. 1396a(a)(28)) is amended by striking out "and tuberculosis".

(f) Section 1903(g)(1) of such Act (42 U.S.C. 1396b(g)(1)) is amended by striking out "(including an institution for tuberculosis)" and "(including tuberculosis hospitals)".

(g) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended by striking out "tuberculosis or" each place it appears.

(h) Section 1905(h)(1) of such Act (42 U.S.C. 1396d(h)(1)) is amended—

(1) by striking out subparagraph (A), and

(2) by redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively.

INDIRECT PAYMENT OF SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

SEC. 112. (a) The first sentence of section 1842(b)(5) of the Social Security Act (42 U.S.C. 1395u(b)(5)) is amended—

(1) by inserting "(i)" after "(A)",

(2) by striking out "(B)" and inserting in lieu thereof "(ii)", and

(3) by inserting before the period the following: ", or (B) to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part".

(b) The second sentence of such section is amended by striking out "or (B)".

MEDICARE RECOVERY AGAINST CERTAIN THIRD PARTIES

SEC. 113. (a) Section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)) is amended—

(1) in the first sentence, by inserting "promptly" after "to be made",

(2) in the second sentence, by inserting "or may be" after "has been", and

(3) by inserting after the second sentence the following new sentence: "The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a law, policy, plan, or insurance (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment), by bringing an action against the entity to which payment has been so made (if the entity is other than the individual entitled to benefits under this title), or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a law, policy, plan, or insurance.".

(b) Section 1862(b)(2)(B) of such Act (42 U.S.C. 1395y(b)(2)(B)) is amended—

(1) in the first sentence, by inserting "or may be" after "has been", and

(2) by inserting after the first sentence the following new sentence: "The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a plan (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment), by bringing an action against the entity to which payment has been so made (if the entity is other than the individual entitled to benefits under this title), or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a plan.".

(c) Section 1862(b)(3)(A)(ii) of such Act (42 U.S.C. 1395y(b)(3)(A)(ii)) is amended—

(1) in the first sentence, by inserting "or may be" after "has been", and

(2) by inserting after the first sentence the following new sentence: "The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a plan (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has

not already made payment), by bringing an action against the entity to which payment has been so made (if the entity is other than the individual entitled to benefits under this title), or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a plan.".

TERMINATION OF AGREEMENTS WITH INSTITUTIONS AND ENTITIES WHERE OWNERS OR CERTAIN OTHER INDIVIDUALS HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 114. Section 1866(b)(2)(G) of the Social Security Act (42 U.S.C. 1395cc(b)(2)(G)) is amended by inserting ", or that any person who has a direct or indirect ownership or control interest of 5 percent of more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a)" after "1126(a)".

THIRTY-DAY COVERAGE FOR SERVICES FURNISHED BY A HOME HEALTH AGENCY WHOSE AGREEMENT HAS BEEN TERMINATED

SEC. 115. (a) Section 1866(b)(4)(B) of the Social Security Act (42 U.S.C. 1395cc(b)(4)(B)) is amended by striking out "the calendar year in which" and inserting in lieu thereof "30 days after".

(b) The amendment made by subsection (a) applies with respect to terminations whose effective date falls after 60 days after the date of the enactment of this Act.

HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 116. (a) Subsection (c)(3)(A) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended—

(1) by inserting "(i)" after "(3)(A)",

(2) by inserting "and including the 30-day period specified under clause (ii)" after "30 days duration every year", and

(3) by adding at the end the following new clause:

"(ii) For each area served by more than one eligible organization under this section, the Secretary (after consultation with such organizations) shall establish a single 30-day period each year during which all eligible organizations serving the area must provide for open enrollment under this section. The Secretary shall determine annual per capita rates under subsection (a)(1)(A) in a manner that assures that individuals enrolling during such a 30-day period will not have premium charges increased or any additional benefits decreased during the 12-month enrollment period for which the individual is enrolling. An eligible organization may provide for such other open enrollment period or periods as it deems appropriate consistent with this section.".

(b) The first sentence of subsection (g)(2) of such section is amended by inserting before the period the following: "and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and re-

served by the Secretary for subsequent annual contract periods to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3)".

(c)(1) Subsection (g)(4)(A) of such section is amended—

(A) by inserting "and other providers of services" after "hospitals",

(B) by inserting "or other appropriate basis for payment established under this title" after "section 1861(v))", and

(C) by striking out "inpatient hospital".

(2) Subsection (h)(2) of such section is amended—

(A) by striking out "skilled nursing facilities" in subparagraph (A) and inserting in lieu thereof "other providers of services",

(B) by striking out "or" after "1861(v))" in subparagraph (A) and in the second sentence and inserting in lieu thereof a comma in each instance,

(C) by inserting "or other appropriate basis for payment established under this title" after "section 1886" in subparagraph (A) and in the second sentence each place it appears, and

(D) by striking out "skilled nursing facility" in the second sentence and inserting in lieu thereof "or other provider of services".

(d) The Secretary of Health and Human Services may phase in, over a period of not longer than three years, the application of the amendments made by subsection (a) to all applicable areas in the United States if the Secretary determines that it is not administratively feasible to establish a single 30-day open enrollment period for all such applicable areas before the end of the period.

FLEXIBLE SANCTIONS FOR NONCOMPLIANCE WITH REQUIREMENTS FOR END-STAGE RENAL DISEASE FACILITIES

SEC. 117. Section 1881(c)(3) of the Social Security Act (42 U.S.C. 1395rr(c)(3)) is amended by adding at the end the following new sentence: "Where the Secretary also determines that the facility's or provider's failure to cooperate with the Secretary's plans and goals does not jeopardize patient health or safety or justify termination of certification, he may, instead of terminating or withholding certification and after reasonable notice to the provider or facility and to the public, impose such other sanctions as may be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of the notice and graduated reduction in reimbursement for all patients.".

REPEAL OF REQUIREMENT FOR END-STAGE RENAL DISEASE NETWORKS

SEC. 118. (a)(1) Paragraph (1) of section 1881(c) of the Social Security Act (42 U.S.C. 1395rr(c)) is amended to read as follows:

"(c)(1) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary may establish a national end-stage renal disease medical information system.".

(2) Paragraphs (2), (4), and (5) of such section are repealed.

(3) Paragraph (3) of such section is amended—

(A) by striking out "the data contained in the network's annual report and such other" and inserting in lieu thereof "such",

(B) by striking out "network plans" and inserting in lieu thereof "the Secretary's plans", and

(C) by striking out "network's plans" and inserting in lieu thereof "those plans".

(4) Paragraph (6) of such section is amended—

(A) by striking out "and network" in the second sentence,

(B) by striking out "(6)" and inserting in lieu thereof "(2)", and

(C) by transferring and inserting it after paragraph (1) of such section.

(b) Section 1881(g) of such Act (42 U.S.C. 1395rr(g)) is amended—

(1) by striking out ", nationally and by renal disease network," in paragraph (1),

(2) by adding "and" at the end of paragraph (13),

(3) by striking out paragraph (14), and

(4) by redesignating paragraph (15) as paragraph (14).

(c) The amendments made by this section shall take effect on a date, established and published by the Secretary and not earlier than January 1, 1984, as of which date the Secretary has in operation an alternative means of performing the essential data collection activities performed on the date of the enactment of this Act by renal disease networks.

TITLE II—MEDICAID RECONCILIATION AMENDMENTS

Part A—Maternal and Child Health Amendments

INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR SERVICES PROVIDED TO CERTAIN PREGNANT WOMEN AND YOUNG CHILDREN

Sec. 201. (a)(1) Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following new sentence: "Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services furnished with respect to a qualified pregnant woman or child (as defined in subsection (n)).".

(2)(A) Section 1903(s)(1)(A) of such Act (42 U.S.C. 1396b(s)(1)(A)) is amended by inserting "or furnished with respect to a qualified pregnant woman or child (as defined in section 1905(n))" after "Indian Health Service".

(B) Section 1903(s)(2) of such Act (42 U.S.C. 1396b(s)(2)) is amended—

(i) by striking out "and" at the end of subparagraph (B),

(ii) by striking out the period at the end of subparagraph (C) and inserting in lieu thereof ", and", and

(iii) by adding after at the end the following new subparagraph:

"(D) by one-half percentage point if the State provides (and provided as of June 30, 1983) for coverage under the plan, under clauses (i) and (ii)(I) of section 1902(a)(10)(A), of—

"(i) all children described in section 1905(a)(i) and in section 1902(a)(10)(A)(ii)(I);

"(ii) all pregnant women whom the State has the option of deeming to be recipients of aid to families with dependent children for purposes of this title by reason of section 406(g)(2); and

"(iii)(I) individuals receiving aid under a State plan under part A of title IV pursuant to section 407 by virtue of being deprived of parental support or care by reason of the unemployment of a parent who is the principal earner (as described in such section), or

"(II) all pregnant women who are members of a family which would be eligible to receive aid under a State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid with respect to dependent children deprived of parental support or care by reason of the unemployment of a parent who is the principal earner (as described in such section).".

(3) Section 1903(t)(1)(A) of such Act (42 U.S.C. 1396b(t)(1)(A)) is amended by inserting "or furnished with respect to a qualified pregnant woman or child (as defined in section 1905(n))" after "Indian Health Service".

(b) Section 1905 of such Act (42 U.S.C. 1396d) is further amended by adding at the end the following new subsection:

"(n) The term 'qualified pregnant woman or child' means—

"(1) a child born on or after January 1, 1983, who is under 5 years of age and who is described in section 1902(a)(10)(A)(ii)(I) and covered under the State plan as an individual described in section 1902(a)(10)(A), or

"(2) a pregnant woman—

"(A) whom the State has the option of deeming to be a recipient of aid to families with dependent children for purposes of this title by reason of section 406(g)(2), or

"(B) who is a member of a family which would be eligible for aid under a State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid with respect to dependent children deprived of parental support or care by reason of the unemployment of a parent who is the principal earner (as described in such section); and

who is not eligible for coverage under the plan, as the plan was in effect on June 30, 1983, as an individual described in section 1902(a)(10)(A).".

(c)(1) Except as provided in paragraph (2), the amendments made by the preceding subsections of this section shall take effect on January 1, 1984, and apply to payments made to providers under State plans on and after that date.

(2) The amendment made by subsection (a)(2)(B) shall apply to payments to States for quarters beginning on or after October 1, 1983.

(3) Notwithstanding any provision of title XIX of the Social Security Act, a State plan approved under such title which did not make all children described in section 1902(a)(10)(A)(ii)(I) of such Act eligible for coverage under the plan as of June 30, 1983, may limit the eligibility of coverage of such children to those who are qualified children described in section 1905(n)(1) of such title.

(d) Effective for payments made to providers under State plans on or after October 1, 1986, paragraph (2) of section 1905(n) of the Social Security Act (added by subsection (b) of this section) is amended to read as follows:

"(2) a pregnant woman who is described in section 1902(a)(10)(A)(ii)(I) and covered under the State plan as an individual described in section 1902(a)(10)(A); and".

PERMITTING ELIMINATION OF "DEEMING" OF INCOME AND RESOURCES WITH RESPECT TO CERTAIN MINOR PREGNANT WOMEN

SEC. 202. (a) Section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)) is amended by striking out "and" at the end of clause (C) and by inserting at the end of clause (D) the following: ", and (E) at the option of the State, do not take into account the financial responsibility of any individual for an applicant or recipient who is a pregnant woman under age 21 and who does not have legal custody over other children, unless the applicant or recipient is the individual's spouse, except that a State may limit the application of this clause (E) to applicants and recipients who live in such an individual's household, in a custodial institution for pregnant women, or in either such a household or such an institution".

(b) The amendments made by subsection (a) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1984.

CLARIFICATION OF MEDICAID ENTITLEMENT FOR CERTAIN NEWBORNS

SEC. 203. (a) Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

"(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains eligible for such assistance.".

(b) The amendment made by subsection (a) shall apply to children born on or after January 1, 1984.

PART B—MISCELLANEOUS MEDICAID CHANGES

MEDICALLY NEEDY INCOME LEVELS

SEC. 211. (a) Section 1903(f)(3) of the Social Security Act (42 U.S.C. 1396b(f)(3)) is amended—

(1) by inserting "(A)" after "(3)", and

(2) by adding at the end the following new subparagraph:

"(B) For purposes of paragraph (1)(B), in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the 'highest amount which would ordinarily be paid to a family of the same size' under the State's plan approved under part A of title IV of this Act shall, at the State's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. In the case of a State which has an applicable income limitation under this subsection which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) for families other than those described in the previous sentence, section 1902(a)(10)(C)(i)(III) shall not prevent the State from establishing under the previous sentence an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families.".

(b) The amendment made by subsection (a)(2) shall apply to payments to States under section 1903 of the Social Security Act for calendar quarters beginning on or after January 1, 1984.

RECERTIFICATION OF NEED FOR STAYS IN SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

SEC. 212. (a) Section 1903(g) of the Social Security Act (42 U.S.C. 1396b(g)) is amended—

(1) by striking out ", skilled nursing facility or intermediate care facility on 60 days" in the matter in paragraph (1) before subparagraph (A) and by inserting in lieu thereof "or intermediate care facility on 60 days, in a skilled nursing facility on 30 days";

(2) by striking out ", skilled nursing facility services, or intermediate care facility services furnished beyond 60 days" in the matter in paragraph (1) before subparagraph (A) and inserting in lieu thereof "or intermediate care facility furnished beyond 60 days or skilled nursing facility services furnished beyond 30 days";

(3) by inserting "or, in the case of services that are skilled nursing facility or intermediate care facility services other than in an institution for the mentally retarded, at least as frequently as provided under paragraph (7)," in paragraph (1)(A) after "every 60 days (";

(4) by adding at the end of paragraph (4) the following new subparagraph:

"(C) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirements of subparagraphs (A) and (B) of such paragraph as applicable to a type of facility or institutional services, if the fraction referred to in paragraph (5)(B) with respect to that quarter for that type of services is equal to or less than 3 one-hundredths.";

(5) by striking out "(5) In" in paragraph (5) and inserting in lieu thereof "(5)(A)(i) Except as provided in subparagraph (B), in";

(6) by adding at the end of paragraph (5) the following:

"(ii) As used in clause (i), the term 'showing' does not include a State's showing made with respect to the requirements of subparagraphs (A) and (B) of paragraph (1).

"(B) In the case of a State's unsatisfactory and invalid showing made with respect to the requirements of subparagraphs (A) and (B) of paragraph (1) with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1), in addition to the amount of any per centum reduction under subparagraph (A), is equal to 5 per centum multiplied by a fraction—

"(A) the denominator of which is equal to the total number of patients, receiving that type of services in that quarter under the State plan, whose records were included in sample onsite surveys conducted with respect to such requirements for that quarter under paragraph (2), and

"(B) the numerator of which is equal to the number of such patients receiving such type of services in that quarter whose records were found under such surveys not to comply with such requirements."; and

(7) by adding at the end the following new paragraph:

"(7)(A) With respect to inpatients of—

"(i) skilled nursing facilities, the frequency of recertifications referred to in paragraph (1)(A) is—

"(I) on or before 30, 60, and 90 days after the date of admittance to the facility, and

"(II) each 60 days thereafter; and

"(ii) intermediate care facilities, the frequency of recertifications referred to in paragraph (1)(A) is—

"(I) on or before 60 and 180 days after the date of admittance to the facility,

"(II) on or before 12, 18, and 24 months after the date of admittance to the facility, and

"(III) annually thereafter.

"(B) For purposes of this subsection, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State can demonstrate that there was good cause for the physician's failure to meet the recertification deadline.".

(b) Such section is further amended by adding at the end the following new paragraph:

"(8) It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this title, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.".

(c) The amendments made by subsection (a) shall apply to calendar quarters beginning on or after January 1, 1984, except that the amendments made by paragraphs (1), (2), and (3) of subsection (a) and section 1903(g)(7)(A) of the Social Security Act (added by the amendment made by paragraph (7) of subsection (a)) shall not

apply to individuals admitted to skilled nursing facilities before January 1, 1984.

WAIVER OF CERTAIN MEMBERSHIP REQUIREMENTS FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS

SEC. 213. Section 1903(m)(2) of the Social Security Act (42 U.S.C. 1396b(m)(2)) is amended by adding at the end the following new subparagraph:

"(E) In the case of a health maintenance organization that—

"(i) is a nonprofit organization with at least 25,000 members,

"(ii) is and has been a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) for a period of at least four years,

"(iii) provides basic health services through members of the staff of the organization,

"(iv) is located in an area designated as medically underserved under section 1302(7) of the Public Health Service Act, and

"(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1115,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII.".

PROHIBITING MEDICAID COPAYMENTS FOR PRESCRIBED DRUGS

SEC. 214. (a) Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Social Security Act (42 U.S.C. 1396o(a)(2)(D), 1396o(b)(2)(D)) are each amended by striking out "or" before "services" and by inserting after "is enrolled" the following: ", or prescribed drugs".

(b)(1) The amendments made by subsection (a) apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1984.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before July 1, 1984.

MAXIMUM AMOUNT OF MEDICAID PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

SEC. 215. Effective beginning with fiscal year 1984, paragraphs (1) through (5) of section 1108(c) of the Social Security Act (42 U.S.C. 1308(c)) are amended to read as follows:

"(1) Puerto Rico shall not exceed $77,100,000,

"(2) the Virgin Islands shall not exceed $2,600,000,
"(3) Guam shall not exceed $2,400,000,
"(4) the Northern Mariana Islands shall not exceed $600,000, and
"(5) American Samoa shall not exceed $1,300,000.".

PAYMENT FOR PSYCHIATRIC HOSPITAL SERVICES

SEC. 216. The provisions of section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)), in so far as they require a reduction of the amount of payment otherwise to be made to a public psychiatric hospital due to the level of care received in such hospital, shall not apply to payments to hospitals before July 1, 1985, and such a reduction made for payments during the 12-month period ending June 30, 1986, and during the 12-month period ending June 30, 1987, shall be one-third and two-thirds, respectively, of the amount of the reduction which would have been made without regard to this section.

TITLE III—RECOVERY OF HILL-BURTON FUNDS

RECOVERY OF HILL-BURTON FUNDS

SEC. 301. (a) Section 609 of the Public Health Service Act (42 U.S.C. 291i) is amended to read as follows:

"RECOVERY

"SEC. 609. (a) If any facility with respect to which funds have been paid under section 606 shall, at any time within twenty years after the completion of construction or modernization—

"(1) be sold or transferred to any entity (A) which is not qualified to file an application under section 605, or (B) which is not approved as a transferee by the State agency designated pursuant to section 604, or its successor, or

"(2) cease to be a public health center or a public or other nonprofit hospital, outpatient facility, facility for long-term care, or rehabilitation facility,

the United States shall be entitled to recover, whether from the transferor or the transferee (or, in the case of a facility which has ceased to be public or nonprofit, from the owners thereof) an amount determined under subsection (c).

"(b) The transferor of a facility which is sold or transferred as described in subsection (a)(1), or the owner of a facility the use of which is changed as described in subsection (a)(2), shall provide the Secretary written notice of such sale, transfer, or change not later than the expiration of 10 days from the date on which such sale, transfer, or change occurs.

"(c)(1) Except as provided in paragraph (2), the amount the United States shall be entitled to recover under subsection (a) is an amount bearing the same ratio to the then value (as determined by the agreement of the parties or in an action brought in the district court of the United States for the district for which the facility involved is situated) of so much of the facility as constituted an approved project or projects as the amount of the Federal participa-

tion bore to the cost of the construction or modernization of such project or projects.

"(2)(A) After the expiration of—

"(i) 180 days after the date of the sale, transfer, or change of use for which a notice is required by subsection (b) in the case of a facility which is sold or transferred or the use of which changes after the date of the enactment of this subsection, or

"(ii) July 1, 1984, in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection,

the amount which the United States is entitled to recover under paragraph (1) with respect to a facility shall be the amount prescribed by paragraph (1) plus interest, during the period described in subparagraph (B), at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate.

"(B) The period referred to in subparagraph (A) is the period beginning—

"(i) in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection, July 1, 1984,

"(ii) in the case of a facility with respect to which notice is provided in accordance with subsection (b), upon the expiration of 180 days after the receipt of such notice, or

"(iii) in the case of a facility with respect to which such notice is not provided as prescribed by subsection (b), on the date of the sale, transfer, or change of use for which such notice was to be provided,

and ending on the date the amount the United States is entitled to under paragraph (1) is collected.

"(d) The Secretary may waive the recovery rights of the United States under subsection (a)(2) with respect to a facility in any State if the Secretary determines, in accordance with regulations, that there is good cause for waiving such rights with respect to such facility.

"(e) The right of recovery of the United States under subsection (a) shall constitute a lien on any facility with respect to which funds have been paid under section 606.".

(b) Section 1622 of such Act (42 U.S.C. 300s-1a) is amended to read as follows:

"RECOVERY

"SEC. 1622. (a) If any facility with respect to which funds have been paid under this title shall, at any time within twenty years after the completion of construction or modernization—

"(1) be sold or transferred to any entity (A) which is not qualified to file an application under section 1621 or 1642 or (B) which is not approved as a transferee by the State Agency of the State in which such facility is located, or its successor, or

"(2) cease to be a public health center or a public or other nonprofit hospital, outpatient facility, facility for long-term care, or rehabilitation facility,

the United States shall be entitled to recover, whether from the transferor or the transferee (or, in the case of a facility which has ceased to be public or nonprofit, from the owners thereof) an amount determined under subsection (c).

"(b) The transferor of a facility which is sold or transferred as described in subsection (a)(1), or the owner of a facility the use of which is changed as described in subsection (a)(2), shall provide the Secretary written notice of such sale, transfer, or change not later than the expiration of 10 days from the date on which such sale, transfer, or change occurs.

"(c)(1) Except as provided in paragraph (2), the amount the United States shall be entitled to recover under subsection (a) is an amount bearing the same ratio to the then value (as determined by the agreement of the parties or in an action brought in the district court of the United States for the district for which the facility involved is situated) of so much of the facility as constituted an approved project or projects as the amount of the Federal participation bore to the cost of the construction or modernization of such project or projects.

"(2)(A) After the expiration of—

"(i) 180 days after the date of the sale, transfer, or change of use for which a notice is required by subsection (b) in the case of a facility which is sold or transferred or the use of which changes after the date of the enactment of this subsection, or

"(ii) July 1, 1984, in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection,

the amount which the United States is entitled to recover under paragraph (1) with respect to a facility shall be the amount prescribed by paragraph (1) plus interest, during the period described in subparagraph (B), at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate.

"(B) The period referred to in subparagraph (A) is the period beginning—

"(i) in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection, July 1, 1984,

"(ii) in the case of a facility with respect to which notice is provided in accordance with subsection (b), upon the expiration of 180 days after the receipt of such notice, or

"(iii) in the case of a facility with respect to which such notice is not provided as prescribed by subsection (b), on the date of the sale, transfer, or changessation for which such notice was to be provided,

and ending on the date the amount the United States is entitled to under paragraph (1) is collected.

"(d) The Secretary may waive the recovery rights of the United States under subsection (a)(2) with respect to a facility in any State if the Secretary determines, in accordance with regulations, that there is good cause for waiving such rights with respect to such facility.

"(e) The right of recovery of the United States under subsection (a) shall constitute a lien on any facility with respect to which funds have been paid under this title.".

(c) Not later than the expiration of the one-hundred and eighty-day period beginning on the date of the enactment of this section, the Secretary shall have in effect regulations and personnel to place in effect the amendments made by this section.

TITLE IV—TECHNICAL AMENDMENTS RELATING TO TITLE V OR TITLE XIX OF THE SOCIAL SECURITY ACT

MISCELLANEOUS TECHNICAL AMENDMENTS

SEC. 401. (a)(1) Section 503(a) of the Social Security Act is amended by striking out "section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213)" and inserting in lieu thereof "section 6503(a) of title 31, United States Code".

(2) Section 506(d)(3) of such Act is amended by striking out "section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212)" and inserting in lieu thereof "section 6503(b) of title 31, United States Code".

(b)(1) Section 1902(a)(9) of such Act is amended by indenting subparagraph (C) two additional ems so as to align its left margin with the left margin of subparagraph (B).

(2) Section 1902(a)(10) of such Act is amended by indenting subparagraph (A) (and each of its clauses and subclauses) two additional ems so as to align its left margin (before clause (i)) with the left margin of subparagraph (B).

(3) Section 1902(a)(13)(A) of such Act is amended by striking out "(A)" and all that follows through "hospital" the first place it appears and inserting in lieu thereof "(A) for payment (except where the State agency is subject to an order under section 1914) of the hospital".

(4) Section 1902(a)(20)(B) of such Act is amended by striking out "periodical" and inserting in lieu thereof "periodic".

(5) Section 1902(a)(20)(C) of such Act is amended by striking out ", section 603(a)(1)(A)(i) and (ii),".

(6) Section 1902(a)(26)(B)(ii) of such Act is amended by striking out "homes" and inserting in lieu thereof "facilities".

(7) Section 1902(a)(33)(A) of such Act is amended by striking out "penultimate sentence" and inserting in lieu thereof "second sentence".

(8) Section 1902(a)(42)(B) of such Act is amended by striking out "part" and inserting in lieu thereof "title".

(9) Section 1902(a) of such Act is amended by striking out "For purposes of paragraphs (9)(A)" and all that follows through "do not include" in the last sentence of the third to last paragraph and inserting in lieu thereof "The provisions of paragraphs (9)(A), (26), (31), and (33) and of section 1903(i)(4) shall not apply to".

(10) Section 1902(f) of such Act is amended by striking out "clause (10)(A)" and "clause (10)(C)" and inserting in lieu thereof "paragraph (10)(A)" and "paragraph (10)(C)", respectively, each place each appears.

(11) Section 1903(g)(4)(B) of such Act is amended—

(A) by striking out "paragraph (26)" and inserting in lieu thereof "paragraphs (26)", and

(B) by striking out "deligence" and inserting in lieu thereof "diligence".

(12) Section 1903(m)(2)(B)(i) of such Act is amended by striking out "(II)" before "for the period" and by striking out "peroid" and inserting in lieu thereof "period".

(13) Section 1903(m)(2) of such Act is amended by aligning subparagraph (C) flush with the left margin.

(14) Section 1905(a)(17) of such Act is amended by striking out "he" and inserting in lieu thereof "the nurse-midwife" each place it appears.

(15) The last sentence of section 1905(a) of such Act is amended by striking out "clauses (vi)" and inserting in lieu thereof "clause (vi)".

(16) The second sentence of section 1905(b) of such Act is amended by striking out everything that follows "the provisions of" and inserting in lieu thereof "section 1101(a)(8)(B).".

(17) Section 1905(d)(1) of such Act is amended by striking out "which meet" and inserting in lieu thereof "the institution meets".

(18) Section 1905(m) of such Act is amended by striking out "he" and inserting in lieu thereof "the nurse".

(19) Section 1915(c)(1) of such Act is amended by striking out "under this part" and inserting in lieu thereof "under this title".

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PURPOSE AND SUMMARY

On June 23, 1983, the House and Senate adopted a First Concurrent Budget Resolution for fiscal year 1984 (H. Con. Res. 91), which included instructions to the Committee on Energy and Commerce. The Committee was directed to recommend changes in programs within its jurisdiction which would result in reductions of Federal outlays of $400 million in fiscal year 1984, $500 million in fiscal year 1985, and $800 million in fiscal year 1986, for a three-year total of $1.7 billion. The Budget Resolution instructions also assumed additional outlays for a Medicaid "Maternal and Child Health" initiative in the amount of $200 million in fiscal year 1984, $250 in fiscal year 1985, and $500 million in fiscal year 1986. In a Report accompanying the Budget Resolution, the conferees stated their intent that: "None of the savings directed to be achieved for

the Medicare program shall come from provisions to increase costs to beneficiaries or from reductions in services to beneficiaries. Rather, savings are to be obtained from improved control on providers of service."

H.R. 4136, as amended, represents the efforts of the Committee on Energy and Commerce to comply with the reconciliation instructions contained in the Conference Report. This legislation was reported to the House of Representatives by a vote of 29–13 on October 20, 1983.

While the Committee agrees in principle with the thrust of the Conference Report, we call the attention of the House to the fact that the competing directives imposed on us could not be resolved.

In essence, the conferees on the Budget Resolution sought to delegate to this Committee the impossible task of achieving substantial Medicare savings while not causing beneficiaries undue hardship from increased out-of-pocket cost. As the Committee discovered during its deliberations on the bill, there is some uncertainty as to the practical ramifications even of the policy choices adopted in this bill. Any direct and indirect increases in beneficiary costs or reductions in service which might occur would violate the instructions of the Conference Report accompanying the Budget Resolution. The Committee's deliberations show that "improved control on providers of service" is no longer a ready new source of budget savings of the magnitude called for in the Conference Report, at least in the context of the policy choices available to the Committee.

In sum, the Committee believes that the conferees' directive to the Committee to make these sizeable savings without increasing beneficiary costs or reducing beneficiary services cannot be met. No policy choices are available to bring this utopian result.

The Committee believes that the Budget Committee should reexamine its reconciliation instructions to provide policy guidance for legislative changes which are objectively achievable. If the Budget Committee believes it is possible to make the required savings in the Medicare program without creating increased beneficiary costs or service reductions, this Committee would welcome information on those policy choices. We do not believe that the problem can be easily resolved and savings targets met without resulting in substantial beneficiary hardship.

HEARINGS

On July 18, 1983, the Subcommittee on Health and the Environment held a hearing on proposals to achieve Medicare cost savings required under the reconciliation instructions contained in the First Budget Resolution. Testimony was received from Representative Wyden, Senator Heinz, the Administrator of the Health Care Financing Administration of the Department of Health and Human Services, and individuals representing the General Accounting Office, the National Council of Senior Citizens, the American Association of Retired Persons, the American Medical Association, the American Clinical Laboratory Association, the National Association of Medical Equipment Suppliers, and others.

The Subcommittee on Health and the Environment also conducted a hearing on July 15, 1983, to consider a proposal for a Medicaid maternal and child health initiative assumed in the First Budget Resolution. The Subcommittee heard testimony from Representative Lehman, Chairman of the Prevention Strategies Task Force of the Select Committee on Children, Youth and Families, and from individuals representing the Children's Defense Fund, the American Academy of Pediatrics, the American Public Health Association, and the National Council of State Public Welfare Administrators.

On April 30, 1982, the Subcommittee on Health and the Environment held a hearing on the extension of the health planning program, at which time a representative from the General Accounting Office presented the results of a study of the administration of the Hill-Burton program, including the recovery provisions, by the Department of Health and Human Services.

COMMITTEE CONSIDERATION

On October 4 and 5, 1983, the Subcommittee on Health and the Environment met in open session to consider a Committee print of October 3, 1983, containing various proposals to implement the reconciliation instructions and related provisions in the First Budget Resolution. On October 5, the Subcommittee, by a record vote of 13–6, ordered the Committee print, as amended, reported to the Committee on Energy and Commerce with instructions that it be introduced as a clean bill. On October 6, 1983, H.R. 4136 was introduced.

On October 19, 1983, the Committee on Energy and Commerce met in open session to consider H.R. 4136. On October 20, 1983, the Committee ordered reported H.R. 4136, as amended, by a record vote of 29–13.

BACKGROUND AND NEED FOR LEGISLATION

The First Concurrent Budget Resolution for FY 1984 (H. Con. Res. 91) contains reconciliation instructions to the Committee on Energy and Commerce directing the Committee to recommend legislative changes in programs within its jurisdiction that would result in reductions of Federal outlays of $400 million in FY 1984, $500 million in FY 1985, and $800 million in FY 1986. The Budget Resolution also assumed additional outlays for a maternal and child health initiative under the Medicaid program amounting to $200 million in FY 1984, $250 million in FY 1985, and $500 million in FY 1986.

COMMITTEE VIEWS

Title I—Medicare Reconciliation Amendments

PART A. PAYMENT AND COVERAGE-RELATED CHARGES

Section 101. Payment for Outpatient Diagnostic Laboratory Tests

Present Law

Under present law, diagnostic laboratory services for ambulatory patients are reimbursed under Medicare on the basis of reasonable charges when furnished by an independent laboratory or by a physician. Payment for such services to hospital outpatients is on the basis of the lower of charges or reasonable cost. These laboratory services are covered under part B of the Medicare program; thus, the beneficiary is subject to the part B deductible and coinsurance requirements.

In 1980, Congress placed limitations on the amount which Medicare will pay a physician for laboratory services, when the services are performed by an independent laboratory. The purpose of this provision was to prevent unreasonable physician mark-ups on such tests. Although this provision has apparently resulted in some savings, it does not deal with the issue, raised by the Department of Health and Human Services' Inspector General, that the charges billed by independent laboratories, when they do not bill the physician, are excessive.

Explanation of Provision

The bill would require the establishment of a fee schedule for all laboratory services except those for hospital inpatients. Payment would be based on the fee schedule unless the actual charge is lower. (The provision under which hospitals laboratories are reimbursed the lower of costs or charges would be repealed.) If lack of consistent coding or other inadequacies in the available data preclude the immediate implementation of a national fee schedule, the schedule may initially be established on a carrier district or other regional basis. However, within three years after the date of enactment, the Secretary would be required to develop and implement a national fee schedule.

The Secretary would be given the discretion to provide for adjustments to the national fee schedule to account for wage variations if the Secretary determines that variations in wages between different areas of the country significantly affect the cost of providing laboratory services and that an adjustment is appropriate.

The initial payment level for the fee schedule would be established at 60% of prevailing charges for the fee screen year beginning July 1, 1983. Thereafter, the Secretary would be required to adjust the fee schedules annually to reflect changes in the Consumer Price Index for all Urban Consumers (U.S. city average) and could make additional adjustments, increasing or decreasing the fee for a particular test, that the Secretary determines are justified by technological changes.

Independent clinical laboratories and hospital laboratories would be required to bill the Medicare program directly, rather than bill-

ing the physician who who ordered the tests. (Laboratories performing tests "under arrangement" with a hospital could continue to bill the hospital for tests performed for outpatients of the hospital.) Physicians would be permitted to bill for clinical laboratory services only if the physician (or another physician with whom the physician shares his practice) personally performed or supervised the performance of the test.

Independent laboratories would be required to accept Medicare assignment. Hospital laboratories would have a similar obligation under the hospital's Medicare participation agreement not to charge a hospital outpatient for whom the hospital's laboratory performs diagnostic tests. With respect to tests performed for patients who were neither inpatients nor outpatients of the hospital, the bill would require that the hospital laboratory accept assignment. Reimbursement for these assigned claims would be at 100% of the fee schedule and applicable deductible and coinsurance amounts would be waived.

Where a physician bills for laboratory services that he personally performs or supervises, the physician may accept or not accept Medicare assignment on a claim by claim basis. When the physician agrees to accept assignment, Medicare reimbursement would be at 100% of the fee schedule amount, and the coinsurance and any applicable deductible would not apply. When the physician chooses not to accept assignment, Medicare reimbursement would be 80% of the fee schedule amount and applicable coinsurance and deductible amounts would apply. The Committee seriously considered requiring physicians to take assignment. However, it was concerned that, in cases in which the laboratory test was a small portion of the total charge for the laboratory's services, the physician might simply bill the patient for the full amount, thus burdening the patient with administrative complications and greater out-of-pocket expense. The Committee believes the provision, taken in its entirety, protects the beneficiaries from having the costs of higher priced tests passed on to them.

The bill provides for the payment of a nominal fee for the drawing of patient specimens. However, this payment may be made only once per encounter to either the physician or the clinical lab, whomever draws the specimen. The Committee intends that the Secretary would determine an appropriate payment amount for these services. The payment may vary under specified circumstances if the Secretary determines that differences in costs make such an adjustment appropriate.

Current law authorizes the Secretary, for certain items and services, to establish Medicare reasonable charge levels at the lowest charge levels at which the item or service is widely and consistently available in a locality. The Committee believes that these provisions of law would no longer be applicable with respect to clinical laboratory services once the fee schedule reimbursement system is implemented.

The Secretary would be directed to simplify current billing requirements for laboratory services. Such simplification may include eliminating requirements that a patient diagnosis appear on a clinical laboratory bill, mechanisms to ensure prompt payment, minimizing the amount of information required for claims process-

ing and facilitating bulk or periodic billing for multiple beneficiaries.

The 1980 amendment, dealing with restrictions on physician markups on tests performed by independent laboratories, would be superseded by the provisions of this bill and would, therefore, be repealed. Since the 1980 amendment was incorporated by reference into the Medicaid State plan requirements, these provisions must also be revised. The bill would provide that Federal matching funds would not be available to the extent that a State paid more for a laboratory test than would be paid for such test under the Medicare fee schedule.

Effective Date

The Medicare provisions would be effective for services furnished on or after March 1, 1984. The Medicaid provision would apply to Federal payments for calendar quarters beginning on or after April 1, 1984.

Section 102. Coverage of administration of hepatitis B vaccine

Present Law

Current law prohibits Medicare coverage of immunizations and vaccines except in the case of pneumococcal vaccine, which the Congress specifically covered in 1980.

Explanation of Provision

The bill would provide Medicare coverage of hepatitis B vaccine for Medicare beneficiaries when the vaccine is administered in a hospital or renal dialysis facility. The applicable Medicare Part B deductible and coinsurance would be waived.

The Committee intends that the Secretary limit those eligible to receive the hepatitis B vaccinations to those at high risk of infection. The Committee anticipates that the Secretary will develop coverage guidelines using available information to define those groups at high risk of contracting this disease, using specifically, but not necessarily exclusively, information developed by the Centers for Disease Control (CDC).

The Committee understands that one of the groups at high risk, identified by the CDC, is the Medicare end-stage renal disease population. Medicare beneficiaries undergoing dialysis treatments for end-stage renal disease are particularly susceptible to hepatitis B and are currently monitored by blood tests, frequently on a monthly basis, for the virus. The Committee believes that this population should be covered by this provision. Vaccinating this group will obviate the need for frequent blood tests and special isolation procedures, thereby saving Medicare expenditures and enhancing the mobility of such patients.

Another high risk group would include patients receiving blood products. It is the Committee's expectation that the number of beneficiaries other than ESRD patients for whom the vaccine is appropriately indicated would be relatively small. In response to concerns expressed by the Department that it might be difficult to monitor and prevent potential over utilization, the bill limits the

setting for administration of the vaccine to hospitals and renal dialysis facilities, which are the settings where it is expected that most of the high risk patients would be identified.

The Committee has given the Secretary the flexibility to develop a payment method that may be different from the usual Medicare reimbursement rules. In developing such a payment system, however, the Committee believes that it should be entirely separate from the composite rate reimbursement system for renal dialysis services. Furthermore, the Committee believes that any payment system should provide a payment amount which reasonably reflects the cost of efficiently providing and administering the vaccine.

Effective Date

The provision would be effective for services furnished on or after January 1, 1984.

Section 103. Part B payment for services of teaching physicians

Present Law

Section 948 of the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) sought to resolve long-standing issues regarding how the Medicare program should reimburse for patient care related services performed by physicians in a teaching setting. Section 948 sets forth conditions which the physician must satisfy in order to be reimbursed under Part B on a charge basis. It also sets forth a formula for calculating the physician's customary charge in such circumstances, which formula is based on the charges collected from non-Medicare beneficiaries for similar services.

The Department of Health and Human Services has encountered great difficulty in trying to draft regulations implementing section 948. It is the Committee's understanding that the difficulty does not arise from the prerequisites for qualifying for charge reimbursement. (It is also the Committee's understanding that these prerequisites are not in conflict with analogous conditions applicable to provider-based physicians and that the two sets of conditions can be administered in a coordinated fashion, where appropriate.)

The difficulties encountered arise from the statutory formula for determining reasonable charges by reference to the "mean" and the "mode" of charges collected in full or substantial part from non-Medicare beneficiaries. First, the formula calls for data which are not available to Medicare carriers and would, in many instances, be difficult and burdensome for the hospital (or other entity doing the billing) to assemble and for the carrier to verify. Second, the formula results in inappropriately low Medicare charges in the case of physicians located in institutions with a high proportion of low-paying patients (including Medicaid patients in states with low fee schedules).

Explanation of Provision

The bill does not change the rules for determining when a physician may be reimbursed on a charge basis. However, it would make two changes in the method for determining charges. First, it would

establish a new floor, below which charges calculated under the present formula could not fall. The floor would be set at 75 percent of the Medicare prevailing charges paid for services in the same locality as the teaching setting. It is the Committee's expectation that the Department will seek ways to simplify the data collection and analysis requirements entailed in implementing the formula in those instances in which it is clear which of the tests will prove to be applicable.

The second change would provide an alternative method to the current statutory formula for determining reasonable charges. If all the "teaching physicians at a particular teaching hospital agreed to take assignment for all Medicare patients they serve in that teaching hospital, then the physicians could have their reasonable charges determined according to the normal Medicare reasonable charge methodology, comparing actual, customary and prevailing charges, without regard to the special statutory formula. Physicians who were not "teaching physicians" would not be required to be part of this agreement and would not be affected by it.

In order to clarify the existing statute and facilitate the implementation of this amendment, the bill also deletes the current language regarding physicians with "a substantial practice outside the teaching setting" and instead requires that the Secretary of Health and Human Services define the term "teaching physician." It is the Committee's intent that the Secretary, in promulgating this definition, would look to such factors as: the existence and nature of an agreement between the physician and the hospital, medical school or related organization respecting the physician's responsibilities and compensation for patient care, supervision of other medical staff, teaching, and research; the physician's participation in a faculty practice plan; the type of appointment, if any, the physician has in the medical school or related organization; and the extent to which the physician's practice is concentrated in the teaching setting.

The provision would be effective with respect to services furnished on or after July 1, 1984, in order to give the Secretary time to promulgate regulations and give physicians time to elect between the alternative methods.

Section 104. Information on physician assignment practices

Present Law

Under current law, physicians may decide, on a claim-by-claim basis, to accept or not accept assignment. That is, for every claim a physician may decide either to accept the amount paid by Medicare reasonable charge as payment in full (except for cost-sharing amounts) or to bill the patient an additional amount.

The assignment system provides inadequate and unpredictable financial protection for Medicare beneficiaries. In 1982, Medicare beneficiaries were responsible for $1.4 billion in charges in excess of Medicare reasonable charges. On unassigned claims, beneficiaries are responsible for an average of 24 percent of the billed charges—that is, billed charges were reduced by an average of 24 percent by Medicare. In addition, the elderly pay the statutorily mandated 20 percent coinsurance on every claim. Moreover, since

only 53 percent of claims are assigned, and since assignment rates very among States from a low of 20 percent to a high exceeding 80 percent, there is substantial variation in the value of Medicare financial protection for beneficiaries residing in different states.

The Medicare assignment system is difficult for beneficiaries to understand. Medicare beneficiaries often have difficulty finding out which physicians accept assignment and frequently do not know whether assignment will be accepted until after the service is rendered. Thus, beneficiaries have difficulty achieving a predicted level of out-of-pocket expenses, and the extent of financial protection provided by Medicare insurance is not uniform.

In the past, in order to make the assignment system easier for beneficiaries to understand, some Medicare carriers have made available information on the assignment rates of individual physicians. However, the Department of HHS has not routinely made this information available throughout the country.

Explanation of Provision

The Committee's bill contains two provisions to improve the assignment situation. The Committee believes these provisions will both simplify the Medicare program for beneficiaries and encourage market competition for physician services.

The first provision requires the Secretary to offer physicians an opportunity to voluntarily sign an agreement to accept assignment for all services furnished to all Medicare patients in the following year. These agreements would be similar to the "participating physician" agreements successfully used by many Blue Shield plans. Under the bill, the Secretary is required to compile directories annually of Medicare "participating physicians." The claim-by-claim assignment system would continue in its current form for physicians who chose not to sign agreements.

The second provision requires the Secretary to compile annually a list of the assignment rates, by percentile intervals not to exceed quartiles, of individual physicians for the previous year. These lists should state that the information is based on the previous year's experience and there are no assurances that any specific physician will accept assignment in an individual case.

The purpose of these two provisions in the provide a basis for Medicare beneficiaries to increase the predictability of their out-of-pocket expenditures. Directories of participating physicians will allow the elderly to improve their ability to select physicians who always accept assignment and thus better protect themselves against extra charges on unassigned claims.

The Committee bill requires the Secretary to notify Medicare beneficiaries annually about the availability of the participating physician directories and the lists of physicians' historical assignment rates. A notice in beneficiaries' social security checks (i.e., a check stuffer) could be a cost effective method to accomplish this requirement.

The Committee bill requires the Secretary to make available, in each district office of the Social Security Administration (SSA), the historical assignment rate lists for the local geographic areas served by that office. The bill also specifies that the historical as-

signment rate lists shall be available by mail from each carrier. The Committee anticipates that, in fulfilling this requirement, the Secretary may impose a nominal charge to cover the costs of printing, mailing and handling the lists.

The directories of participating physicians should be readily available to individual beneficiaries. In this regard, the Secretary may desire to utilize toll-free hot lines at the carriers to provide beneficiaries with names, addresses and phone numbers (if available) of participating physicians and confirm if specific physicians have agreed to accept assignment. The Secretary should also consider sending copies of the directory to all participating physicians. This procedure would confirm to physicians that their name is published in the directory, an give them names of participating colleagues to whom they can refer Medicare patients.

The Committee intends that the directories and lists be prepared in a manner that will be of most value to beneficiaries. They should contain the complete name and address of each physician and should be prepared at least for each carrier jurisdiction and, if practical, for smaller geographic areas such as cities, counties or zip codes. They could be organized by physician specialty and geographic area and alphabetically within each specialty and geographic area. In addition, all physicians should be listed by name in an alphabetical index. With respect to the lists of historical assignment rates, the Secretary may desire to include an indication of the volume (or range of volume) of services on the lists or to exclude those physicians who infrequently provide services to Medicare beneficiaries. In calculating the assignment ratio, the Secretary may present the assignment information as the percent of claims or services, or the total charges on those claims that are assigned.

While the Committee bill refers to physicians, the Committee intends that the participating physician agreements and historical assignment rate lists may also apply to other persons, such as suppliers who render services to beneficiaries under Part B. The Committee also notes that while the bill requires participating physicians to agree to accept assignment prospectively for all services provided to Medicare patients in the following year, it also allows physicians to accept payment under Section 1870(f)(1) for services provided to deceased beneficiaries. Section 112 of the Committee bill allows the indirect payment of supplementary medical insurance benefits. The Committee intends that participating physicians be permitted to bill under the indirect payment method and be subject to those provisions if the Medicare beneficiary is covered under a plan approved for the indirect payment method.

The Committee believes that, in conjunction with the preparation of the directory of participating physicians, the Secretary should consider selective administrative improvements and paperwork simplifications as incentives to encourage physicians to sign participation agreements and accept assignment. The Committee believes that the Secretary should consider administrative incentives such as: (1) electronic billing transmission lines dedicated to the receipt of claims from participating physicians; and (2) using procedures under which the physician does not have to submit a separate bill to the beneficiary for the deductible and coinsurance,

but rather receives payment from the other third party payors which may cover cost-sharing or make full payment or in which the cost-sharing is billed to the beneficiary on behalf of the physician.

The Committee believes that administrative improvements, combined with the availability of information from directories and toll-free hot lines, would make it desirable for physicians to become Medicare participating physicians. Information would allow participating physicians the opportunity to increase their Medicare patient volume and administrative improvements could reduce paperwork, make it easier for physicians to receive amounts due, and reduce uncertainty about collections.

Effective Date

The provision would take effect upon enactment.

Section 105. Study of medicare part B payment

Present Law

In FY 1984, Medicare physician expenditures will be about $16 billion. Physician spending represents about 25 percent of Medicare benefit payments and is the second largest component after spending for Medicare hospital services. Medicare spending also represents about 17 percent of all spending for physician services. Medicare physician expenditures have increased rapidly in the past few years—from $3.7 billion in 1976 to $16 billion in 1984.

Medicare's current customary, prevailing and reasonable charge (CPR) reimbursement system has been criticized for a number of reasons. These problems include the relative reimbursement rates which tend to favor surgical and highly technologic procedures over primary and cognitive care, physicians located in urban areas over those practicing in rural areas, and care provided in hospitals over that provided in ambulatory settings. For example, studies indicate that surgical procedures are often compensated at rates three to seven time per hour those of primary care visits. Similary, studies show care provided in hospitals to be reimbursed at hourly rates greater than ambulatory care. Higher payment levels for procedural and in-hospital care can provide financial incentives for the provision of these types of services.

Medicare policies relating to the assignment of claims provide inadequate and unpredictable financial protection for Medicare beneficiaries. In 1982, Medicare beneficiaries were responsible for $1.4 billion in charges in excess of Medicare reasonable charges. Beneficiaries receive uncertain financial protection from Medicare since only 53 percent of claims are assigned.

The Medicare physician reimbursement system also permits physicians to increase their overall level of payments by increasing the volume and complexity of services for which claims are submitted. The current physician payment system does not include any limits on the volume of services provided by physicians and the lack of precision in the definition of services in the current system allows physicians to increase the complexity of services provided to the elderly. Taken together, increases in volume and complexity permit

the increase in total payments to physicians to far exceed the rate of increase in fees. In FY 1983 total payments to physicians under Part B increased by 18 percent, while the increase in medicare prevailing charges was limited by the Medicare Economic Index to 5.85 percent.

Explanation of Provision

Section 105 of the Committee bill requires the Secretary to conduct a study of Medicare Part B payments and submit a report to Congress no later than December 30, 1984. The Committee bill directs the Secretary to study three important aspects of Medicare Part B payments: (1) inequities by type of service and location of care in the relative amounts paid to physicians; (2) incentives for physicians to accept assignment; and (3) incentives for physicians not to increase the volume of hospital or physician services.

The Committee intends the Secretary to analyze payments to physicians by type and location of service and to propose changes in the Medicare CPR system necessary to achieve more equitable payment levels. The Secretary should, in particular, consider revisions in Medicare fees necessary to achieve greater uniformity in payments per hour, adjusted for complexity, investment in professional training and overhead expenses. Special attention should be paid to addressing inequities between cognitive services and medical and surgical procedures. Psychiatric and other mental health services should be considered as cognitive services for the purposes of the study. The implications of proposed reimbursement changes on beneficiary costs should be considered.

The Committee notes that the Department has long supported work related to physician payment by researchers at Harvard University, the Urban Institute and other institutions. The Committee anticipates that the report under Section 105 will draw upon the work completed to date. The report shall include at least one fully developed fee schedule for payment under Part B. The Committee anticipates that the fee schedule will be consistent with the HCFA Common Procedure Coding and Terminology system now being adopted by the Part B carriers.

The bill also requires the Secretary to develop centralized data bases utilizing information from the Medicare carriers regarding the utilization of Part B services; the assignment rates and characteristics of physicians and suppliers; actual, customary and prevailing charge distributions; and differences in charge distributions among different specialities and localities. More than one data base may be developed as the Secretary determines is appropriate and the data bases may be prepared on a sample basis.

Effective Date

The study is to be completed and the report submitted to the Congress not later than December 30, 1984.

Section 106. Pacemaker reimbursement and review reform

Present Law

Current law provides for the services associated with the implantation of cardiac pacemakers and post-implantation monitoring of these devices to be reimbursed under Part B. A number of criticisms have been raised concerning current Medicare policies and practices relating to cardiac pacemakers.

The most serious of these criticisms focuses on excessively frequent transtelephonic monitoring of pacemakers. This problem stems from the common practice of routinely monitoring pacemakers as often as once a month. With the introduction of lithium batteries, which are more reliable than the earlier mercury-zinc batteries, most experts believe monthly monitoring is no longer necessary.

Similarly, fees for the implantation of pacemakers have been criticized as excessive. These fees were set at relatively high levels at the time when pacemakers were first introduced and implantation was a difficult and somewhat lengthy procedure. These fees have not been reduced in recent years, although improvements in a pacemaker technology have substantially simplified the implantation procedure.

Finally, questions have been raised concerning the warranty practices of the Medicare program. It has been suggested that Medicare has not always received the credits due from manufacturers of malfunctioning pacemakers.

Explanation of Provision

Section 106 of the Committee bill includes provisions responding to each of the three criticisms of current Medicare pacemaker policies.

Subsection (a) would require the Secretary of Health and Human Services to issue revisions by February 1, 1984 to the current guidelines on the frequency of transtelephonic monitoring procedures which are reasonable and necessary. The Secretary, through the Assistant Secretary of Health, is now reviewing Medicare policies in this area. As a part of this review, the American College of Cardiology, the American Heart Association, the American Medical Association, and many other organizations and individuals with expertise in this area will provide materials to the Department. It is anticipated that the February 1, 1984 date provides the Department the necessary time to complete its analysis and issue revised guidelines.

The bill provides that, if the Secretary has failed to issue such revised guidelines February 1, 1984, payments under Medicare will be limited to those specified in the legislation. The bill limits the frequency of transtelephonic monitoring procedures to no more than: (1) weekly during the first month of implantation; (2) once every two months during the period representing 80 percent of the estimated life of the device; and (3) monthly thereafter. These provisions apply only to single-chamber cardiac pacemakers powered by lithium batteries and not to older mercury-zinc battery pacemakers or to the new dual-chamber pacemakers. In addition, the

bill provides that the limitations would not apply when special medical factors, including possible evidence of pacemaker malfunction, justify more frequent monitoring.

Subsection (b) of Section 106 requires the Secretary to review and report to the Congress on the appropriateness of the current rate of physician reimbursement for services associated with implantation and replacement of pacemakers and pacemaker leads. In conducting this review, the Secretary is to take into account the amounts recognized as reasonable with respect to the procedures and the time and difficulty of the procedures compared to those when such rates were first established. The Committee thus intends that the Secretary shall take into consideration improvements in the case of pacemaker implantation and reductions in the time required for such procedures that have occurred over the past decade. Because some analysts believe that fees for implantation are at least 20 percent higher than can be justified, the Secretary is required to take into consideration the reduction of such recognized rates by 20 percent. Since this report is of a limited nature, the Secretary is to complete it by April 1, 1984. The Committee notes that such a short time frame will require the use of intramural analysts, the adapting of existing extramural arrangements, or special expedited contracting procedures.

Finally, subsection (c) of the bill requires the Secretary, through the Food and Drug Administration, to establish a registry of all cardiac pacemaker devices and leads for which payment is made by Medicare. The registry will include the manufacturer, model, serial number, manufacturer's price, the name of the recipient, the date and geographic location of the implantation or removal, and the name of the physician, hospital or other provider. The registry shall include any express or implied warranties associated with the device and any other information which the Secretary deems appropriate.

The purpose of the registry is to assist the Secretary in determining when Medicare payments for a replacement pacemaker may properly be made, in determining when inspection by the FDA may be necessary for purposes of review and testing for malfunctions of pacemakers, and in carrying out such other studies as the Secretary may determine appropriate. The Secretary is specifically prohibited from identifying any recipient of a pacemaker by name.

In any case where the Secretary has reason to believe that replacement of a pacemaker is related to its malfunction, the Secretary is permitted to require the testing of such device by the FDA or be present at the testing by the manufacturer. This provision does not, of course, require the explantation of a pacemaker for other than medical reasons.

Effective Date

The provision would be effective upon enactment. The study of reimbursement provided by subsection (b) is to be completed by April 1, 1984.

Section 107. Payment for debridement of mycotic toenails

Present Law

Routine foot care is not covered under the Medicare program; however, Medicare does allow reimbursement to physicians for debridement of mycotic toenails (i.e., the trimming of toenails with a fungal infection) which cannot be performed by a nonprofessional.

There has been considerable concern regarding the frequency with which this procedure is taking place. The Health and Human Services Inspector General conducted a review in Virginia and concluded that this benefit was being abused, because the procedure was being performed more frequently than necessary and was being performed on patients (particularly nursing home patients) who did not require professional care.

Explanation of Provision

The bill would require the Secretary to deny coverage under the Medicare program for debridement of mycotic toenails if performed more frequently than once every 60 days. Exception would be authorized if medical necessity were documented by the physician.

It is the intent of the provision to assure that payment will not be made for debridement performed more frequently than every 60 days; however, the Secretary may wish to evaluate the practice further and may determine that a tighter standard is more appropriate. It is not the intent of this provision to prohibit the Secretary from establishing a standard which is more restrictive than that provided in the statute. The Secretary would not be prohibited from establishing a rule limiting payment to debridement performed less frequently than every 60 days (except as medically necessary).

Effective Date

The provision would be effective upon enactment.

PART B. MISCELLANEOUS ADMINISTRATIVE CHANGES

Section 111. Repeal of special tuberculosis treatment requirements and requirement of accreditation for psychiatric hospitals

Present Law

Present law contains a number of provisions intended to assure that institutional services provided to Medicare and Medicaid patients suffering from tuberculosis are not custodial in nature and that such treatment can reasonably be expected to improve the patient's condition or render the condition noncommunicable.

Present law also requires that pyschiatric hospitals (and distinct parts of hospitals that are treated as psychiatric hospitals) be accredited by the Joint Commission on Accrediation of Hospitals (JCAH) in order to participate in Medicare and Medicaid.

Explanation of Provision

The bill repeals these special provisions and requirements. Advances in the active treatment of tuberculosis make such safeguards against paying for custodial care for tuberculosis patients unnecessary. The proposal also eliminates the special provider category in present law for tuberculosis hospitals in the Medicare and Medicaid programs.

The bill further repeals the requirement that psychiatric hospitals be accredited by the JCAH in order to participate in Medicare and Medicaid.

Effective Date

The provisions would take effect upon enactment.

Section 112. Indirect payment of supplementary medical insurance benefits

Present Law

Current law does not, in general, permit payments to be made to anyone other than a beneficiary or an entity providing services.

Explanation of Provision

The bill permits Medicare part B payments to be made to a health benefits plan if the beneficiary agrees in writing and if the physician or other supplier agrees to accept the plan's payment as payment in full. The primary purpose of this provision is to enable payment to be made to an employee group that arranges with physicians and others to furnish services to members of the group.

Effective Date

The provision would take effect upon enactment.

Section 113. Medicare recovery against certain third parties

Present Law

Under current law, the Medicare program may make benefit payments for services for which other third party insurance programs (e.g., worker's compensation, auto or liability insurance, and employer health plans) are ultimately liable for some or all of the costs. However, the Secretary does not now have the right of subrogation, to become a party to claims against other liable parties, or to recover directly from such parties.

Explanation of Provision

The bill establishes the statutory right of Medicare to recover directly from a liable third party, if the beneficiary himself does not do so, and to pay a beneficiary, or on the beneficiary's behalf, pending recovery where such third party is not expected to pay promptly. The bill would also permit the Secretary to recover directly from the third party whether or not the beneficiary brings suit to recover and subrogate to the United States the right of the individ-

ual or anyone else to payment from the third party. These provisions are intended to improve the ability of the Medicare program to obtain reimbursement to which it is entitled by law. The bill would not permit Medicare to bring an action against a beneficiary who had already been paid by the third party. Rather, the normal Medicare rules with respect to collection of overpayments would apply.

Effective Date

The provision would be effective upon enactment.

Section 114. Termination of agreements with institutions and entities where owners or certain other individuals have been convicted of certain offenses

Present Law

Current law authorizes the Secretary to bar from participation in Medicare (and to direct State agencies to bar from Medicaid) a person convicted of program-related criminal offenses. It also authorizes the Secretary to refuse either to enter into or to renew a Medicare provider agreement with an entity in which ownership or control is held by a person so convicted.

Explanation of Provision

The bill extends the Secretary's authority to terminate Medicare participation (and to direct State agencies to terminate Medicaid participation) by any entity in which ownership or controlling interest is held by a person convicted of program related criminal offenses, or in which an officer, director, agent or managing employee was convicted of such criminal offense.

Effective Date

The provision would take effect upon enactment.

Section 115. Thirty-day coverage for services furnished by a home health agency whose agreement has been terminated

Present Law

Under current law, if Medicare participation of a home health agency is terminated, the Secretary is required to continue to pay for services provided to a beneficiary until the end of the calendar year in which the termination took place. This requirement is only applicable to services provided under an individual plan of care established prior to the termination of the agency.

Explanation of Provision

The bill changes the period of allowable coverage from the end of the calendar year to 30 days after termination. This brings the provisions for home health agencies into conformity with provisions for hospitals and skilled nursing facilities.

Effective Date

The provision would apply with respect to terminations whose effective date falls after 60 days after the date of enactment.

Section 116. Health maintenance organizations and competitive medical plans

Present Law

This provision deals with three aspects of the current statutory requirements applicable to health maintenance organizations (HMO's): open enrollment periods; additional benefits for enrollees; and direct Medicare payments to providers.

Under current law, HMO's are required to have an open enrollment period of at least 30 days each year, during which they must accept Medicare beneficiaries up to the limit of their capacity. However, if there is more than one HMO in an area, there is no current requirement that the open enrollment period be coordinated. If the HMO's had different open enrollment periods, this could be confusing to beneficiaries and make it difficult for them to select their preferred choice or to change their election.

Current law also requires an HMO with a risk-sharing contract to provide enrollees with either additional health service benefits or reductions in their premiums or other charges, if the adjusted community rate (ACR) for its Medicare enrollees is less than the Medicare payments it receives for those enrollees. The additional services or premiums and charge reductions must be equal in value to the difference between the ACR and the Medicare payments. Moreover, the current law has been interpreted to mean such revisions must be made, in full, each year. This can lead to substantial and unpredictable variations from year to year in the benefits or charges under the HMO plan.

The third provision of current law affected by this provision is the authority of HMO's to have the Medicare program reimburse directly other providers with whom the HMO has made an arrangement to furnish services to the HMO's Medicare enrollees. However, under current law, this provision is restricted to hospitals in the case of risk-sharing HMO's and to hospitals and skilled nursing facilities in the case of cost-based HMO's.

Explanaiton of Provision

Coordinated open enrollment.—This bill would require the Secretary to coordinate the open enrollment periods in each area served by two or more participating HMO's. The purpose of this amendment is to give beneficiaries, who are considering enrolling in an HMO, the opportunity to enroll in any of the competing plans during a coordinating enrollment period. By coordinating the period, beneficiaries can compare each HMO's benefit package before selecting one or changing to another, and thereby make a more informed and thoughtful decision about which plan best meets their particular health care needs.

To carry out this provision, the Secretary would designate geographic areas around the country which are served by two or more participating HMOs. For each area, the Secretary would determine

the 30-day period (during a 12-month period) which provides the best opportunity for Medicare beneficaries to enroll.

Before designating the period, the Secretary would consult with participating HMOs concerning the timing of the period and would consider all factors which bear on the ability of the participating HMOs to enroll the maximum number of beneficiaries during the period. Some of those factors are the availability of staff and facilities during the period and peak enrollment periods of non-Medicare enrollees. This required consultation is critical because the capacity of the participating plans to enroll Medicare beneficaries will vary throughout the year.

When the periods preferred by participating HMOs can not be accommodated, the time selected by the Secretary should minimize disadvantages for all organizations to the greatest extent possible. Similarly, when a new HMO begins participation, the Secretary should minimize disruption for existing contractors, but attempts to afford equitable treatment to the new plan.

Consideration of these complex, interrelated factors is necessary even though it will be difficult. Beneficiaries will be best served by a coordinated open enrollment period which is timed so that all HMOs participate and make available a significant portion (if not all) of their new capacity for new Medicare enrollees for that year.

The Committee's amendment also permits participating HMOs to hold open enrollment for a longer period than the required 30 days, either immediately before or after the shared open enrollment period or at other times. In order to exercise this election, an HMO's capacity to serve new Medicare members could be allocated among its open enrollment periods.

As noted, the Committee recognizes that, in any given year, a participating HMO may have capacity limitations. In determining the limit of an HMO's projected enrollment growth, the utilization experience of the Medicare population, the capacity of the HMO's facilities and any other relevant factors. However, in applying these factors, the Secretary should assure that an HMO does not overstate its projected enrollment growth and medical beneficiary utilization in order to reduce its capacity for new Medicare members.

The Committee determined that a coordinated open enrollment period best serves beneficiaries if they are assured that their premiums will not increase or their benefits decrease during their enrollment period (which is typically for a 12-month period). In order to make this assurance possible, the Secretary would be required to establish an HMO's rates for the same period as the beneficiary is enrolling. Under these circumstances, the HMO's benefit package would be set for the year for which the beneficiary is enrolled.

Section 1876(c) provides for Secretarial review of marketing materials developed by participating HMOs to assure that they are responsible and informative. With the addition of the Committee's amendment requiring coordinated open enrollment, the Secretary would also review these materials to assure that beneficiaries can compare the organizations available to them. While formats may differ, the basic information needed to make an appropriate choice among alternatives should be clearly stated by each organization, including the scope of benefits, premiums and other out-of-pocket

costs, the location of facilities, how to use the plan, disenrollment rights and grievance procedures.

Section 1876 established an entirely new HMO reimbursement scheme for the Medicare program. Its implementation entails the development of policies and procedures which, at the time of this report, are not finalized. This amendment establishes another procedure which is new to Medicare and which may involve some difficulty in administering. In order to permit the equitable and orderly implementation of coordinated open enrollment periods while the program is being started, the Committee has authorized the Secretary to phase-in this requirement during a period of not more than three years. However, the Committee expects the Secretary to make every effort to implement coordinated open enrollment as soon as possible and not wait until the second or third year.

Benefit stabilization fund. In order to avoid confusion and substantial variations from year to year in the HMO's benefit package, the bill would allow an HMO, with the Secretary's approval, to place a portion of the funds required to be used for additional benefits in a benefit stabilization fund. The fund would allow the HMO to stabilize additional benefits from year to year.

While it would be the HMO's option to create the fund, the amount placed in the fund would be approved and held by the Secretary. If the Secretary determined it necessary, a maximum on the amount which could be withheld could be established by regulation.

HMO payments to providers of service.—The bill would expand the types of providers to whom Medicare can make payment for the HMOs. The Committee believes this amendment is consistent with the original intent of the HMO legislation and will simplify the HMO's administration of its plan.

Effective Date

The provision would take effect upon enactment.

Section 117. Flexible sanctions for noncompliance with requirements for end-stage renal disease facilities

Present Law

Current law and regulations provide for decertification of end-stage renal disease (ESRD) facilities that are not in complete compliance with Medicare program requirements.

Explanation of Provision

The bill allows the Secretary to apply intermediate sanctions, such as a graduated reduction of, or denial of a portion of, reimbursement to ESRD facilities, when noncompliance does not jeopardize patient health or safety or justify decertification of such facilities. Noncompliance would, in these cases, mean noncompliance primarily with administrative requirements. The bill would make the sanctions imposed on ESRD facilities comparable to those of nursing homes which are out of compliance.

Effective Date

The provision would take effect upon enactment.

Section 118. Repeal of requirement for end-stage renal disease networks

Present Law

The current statute requires that the Secretary of Health and Human Services establish network organizations to assist in the administration of the End Stage Renal Disease Program. Network organizations are comprised of representatives of the ESRD facilities in the network's geographical area, as well as patient representatives. They are directed to perform a variety of functions, including planning, setting goals and objectives, monitoring patient care, and compiling data on ESRD patients and services that is useful to the Department in administering and evaluating the program.

Explanation of Provision

The bill would eliminate the statutory requirement for networks, as well as the various statutory responsibilities imposed on them. The Secretary would be expected to carry out these responsibilities through other means. The collection and maintenance of data is particularly vital to the efficient and effective administration of the program, and the Secretary would have to make sure that this function is maintained, without interruption, by some other than entity.

Effective Date

The networks could not be eliminated until the Secretary has an alternative mechanism in operation for performing the data collection activities currently performed by networks. This could not, in any event, take place before January 1, 1984.

Title II—Medicaid Reconciliation Amendments

PART A—MATERNAL AND CHILD HEALTH AMENDMENTS

Section 201. Increased Federal medical assistance percentage for services provided to certain pregnant women and young children.

Under current law, States must provide Medicaid coverage to poor women and children who are receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. In order to qualify for AFDC benefits, a woman and her children must not only meet the State's income and assets standards for poverty, but must also fall into the AFDC category of household—that is, a one-parent family with one or more dependent children. Most pregnant women and children in two-parent families, and first-time pregnant women, are excluded from AFDC, and often Medicaid, no matter how poor they may be.

States have the option of extending Medicaid coverage to low-income pregnant women and children who do not meet the narrow

AFDC categorical requirements. There are four relevant optional coverage groups. One is first-time pregnant women. A State may "deem" a first-time pregnant woman eligible for Medicaid from the date of medical verification of pregnancy if the woman would be eligible were the unborn child to be considered a dependent child. It is the Committee's understanding that, as of June 30, 1983, all but 7 States (Arkansas, Indiana, Maine, New Hampshire, Oklahoma, Texas, and Virginia) had opted to "deem" poor first-time pregnant women as eligible for Medicaid. Of the States that do extend coverage to first-time pregnant women, 3 (Delaware, Louisiana, and New Mexico), do not cover these women from the date of medical verification of pregnancy, resulting in a loss of coverage for critical prenatal care.

The second optional coverage group is two-parent families who meet the State's AFDC income and resource standards but whose principal earner is unemployed. States may choose to provide cash assistance to such AFDC-UP (Unemployed Parent) households, thereby making the women (including first-time pregnant women) and children in these families eligible for Medicaid; or they may choose to extend Medicaid coverage but no cash assistance to such families. The Committee's information is that, as of June 30, 1983, 26 States (Alabama, Alaska, Arkansas, Florida, Georgia, Idaho, Indiana, Louisiana, Maine, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Carolina, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming) did not extend Medicaid coverage to pregnant women and children in poor two-parent families where the principal earner is unemployed.

A third relevant optional coverage group is children under age 18 (or, at the State's option, age 21), including those in poor two-parent families that meet the State's AFDC income and resource standards. (This group is sometimes referred to as the "Ribicoff" children, a reference to the former Senator who was the principal sponsor of the legislative authority for such coverage). The Committee understands that, as of June 30, 1983, 28 States (Alabama, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Kentucky, Louisiana, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, and Wyoming) did not extend Medicaid coverage to all children under 21 (or 18) in poor two-parent families. (Many of these States did, however, extend Medicaid coverage to certain "reasonable categories" of such children, such as children in foster care.)

A final relevant optional group includes pregnant women in poor two-parent working families whose children, if born, would be eligible for Medicaid as "Ribicoff children." The Committee understands that, as of June 30, 1983, 32 States (Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Carolina, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Virginia, Washington, West Virginia, and Wyoming) did not extend coverage to this group.

As a result of these variations State Medicaid eligibility policies, many desperately poor low-income pregnant women and children have no health care coverage. The lack of coverage, in turn, makes it extremely difficult for these women to receive adequate prenatal care, since many hospitals and physicians will simply not treat patients who have no source of payment. For example, a 1982 survey of 1,458 low-income pregnant women in Oregon, many of who had no health coverage, indicates that 10 percent were receiving no prenatal care; 13 percent had made no plans for delivery; 9 percent were planning to show up at the hospital in labor, presumably hoping that they would be admitted; and 4.5 percent (66 women) reported that they were having home deliveries because they had no money for hospital care.

Over the last several years, the Committee has heard extensive testimony on the cost-effectiveness of prenatal care and on its value to the health of both the newborn and the mother. The Committee record is also replete with documentation of the importance of adequate medical attention for infants and young children in preventing unnecessary mental and physical developmental problems. Testimony received by the Select Committee on Children, Youth, and Families buttresses this record. In the view of the Committee, an investment in adequate health care for low-income pregnant women and young children is among the most intelligent expenditures of funds that the Federal government could conceivably make.

Under current law, the Federal government matches State outlays for services provided to Medicaid eligibles at a rate that varies from 50 percent to 77 percent of the State's expenditures. The State's actual Federal matching rate depends upon the State's per capita income; the higher the per capita income, the lower the Federal matching rate. Thus, States must now pay between 23 percent and 50 percent of the cost of any services provided to any of the optional coverage groups. The Committee bill seeks to eliminate any financial barriers that might discourage States from exercising their existing options to extend Medicaid coverage to low-income pregnant women and young children who do not fit the narrow AFDC category by making Federal matching payments available at a 100 percent rate for four low-income groups: first-time pregnant women; pregnant women in two-parent families where the principal earner is unemployed; pregnant women in other poor families; and children up to age 5 in two-parent families.

With respect to first-time pregnant women, the Committee bill provides that those States which, as of June 30, 1983, did not offer Medicaid coverage to first-time pregnant women from the date of medical verification of pregnancy, would be able to do so with the Federal government assuming 100 percent of the costs of services to this population. In determining whether a first-time pregnant woman was poor, the State would use the income and resources standards under its AFDC program. Services for these first-time pregnant women would be of the same amount, duration, and scope as the benefits available to AFDC recipients under the State's plan, including prenatal care, delivery, and postpartum care (including treatment for complications resulting from the pregnancy).

With respect to pregnant women in two-parent families, the Committee bill provides that those States which, as of June 30, 1983, did not offer Medicaid coverage to two-parent families where the principal earner is unemployed (whether or not the members of those families also received cash assistance), may extend coverage to pregnant women in such families, including first-time pregnant women in such families, with Federal matching payments at a 100 percent rate. For the fiscal years 1984, 1985, and 1986, the 100 percent Federal matching rate would be limited to services for pregnant women, including first-time pregnant women, in two-parent families where the principal earner is unemployed. Beginning in fiscal year 1987, the 100 percent Federasl matching rate would apply not only to services for pregnant women in two-parent families where the principal earner is unemployed, but also pregnant women, including first-time pregnant women, in all two-parent families that meet State AFSC income and resource standards. The States choosing to include such pregnant women in their Medicaid programs may begin coverage as of medical Verification. Services for these pregnant women must be of the same amount, duration, and scope as the benefits available to AFDC receipients under the State's plan, including prenatal care, delivery, and postpartum care (including treatment for complications resulting from pregnancy).

With respect to children, the Committee bill provides that those States which, as of June 30, 1983, did not offer Medicaid coverage to all "Ribicoff children" from the time of birth through age 18 or 21, may receive 100 percent Federal matching payments for the costs of services to this group. Beginning in FY 1984, a State could extend coverage to all children in families that meet State AFDC income and resources standards born on or after January 1, 1983. A State could continue to receive Federal matching payments at a 100 percent rate for such children, up to age five.

Under current law, States are allowed to limit the coverage of "Ribicoff" children to reasonable classifications, such as children in foster care, but age is not a reasonable classification. The Committee bill makes no change in current law in this regard. However, the Committee bill does allow States that qualify for the 100 percent Federal matching rate for children in two-parent families to limit coverage of such children to those born on or after January 1, 1983. A State would not be required to extend coverage to children born prior to January 1, 1983, in order to receive the special Federal matching rate. A State could, of course, elect to extend Medicaid coverage to all financically eligible children under 18 (or 21), but the Federal matching payments for the children in this group born before January 1, 1983, would be made at the State's normal rate.

Under the Committee bill, these groups of pregnant women and children that qualify for special Federal matching payments are to be treated, for all purposes, as an optional categorically needy group under current law. Thus, if a State chooses to add one or more of such groups, it must do so through State Medicaid plan amendments of general applicability to all potentially eligible persons under the State plan.

The Committee recognizes that those States which already cover first-time pregnant women, two-parent unemployed families, and children under 18 or 21 in two-parent families will not qualify for

the 100 percent Federal matching rate for these three groups. (In FY 1987, when the 100 percent Federal matching payments are available for pregnant women in all two-parent families, these States could extend coverage to this additional group at the higher matching rate). The Committee bill therefore provides for a reduction in the Federal matching penalty that these States would otherwise experience in FY 1984.

Under current law, Federal matching payments to all States are reduced by 4 and ½ percent. States can reduce this penalty in a number of ways, such as the operation of a qualified hospital rate-setting system. Under the Committee bill, States that, as of June 30, 1983, covered all qualified pregnant women and children, and are therefore ineligible for the increased Federal matching payments, will receive a ½ percentage point reduction in their matching penalty for FY 1984. It is the Committee's understanding that 13 States will qualify for this ½ percentage point "bonus:" California, Connectiucut, the District of Columbia, Iowa, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, Pennsylvania, Vermont, and Wisconsin.

For purposes of determining whether a State qualifies for the ½ percentage point reduction, a State must, as of June 30, 1983, provide Medicaid coverage to (1) first-time pregnant women who the State has the option of "deeming" to be eligible for AFDC, from the date of medical verification of pregnancy (coverage from the 6th month or 9th month is not sufficient); (2) two-parent families in which the principal breadwinner is unemployed, whether they receive cash assistance under the AFDC–UP program or simply Medicaid coverage, and (3) all children under 18 (or 21) who meet State income and resource standards, whether or not the State covers first-time pregnant women on the basis of their unborn child (coverage of only one or more "reasonable categories" or "Ribicoff children" would not be sufficient for this purpose). States that, as of June 30, 1983, did cover all "Ribicoff children" may not thereafter impose coverage limitations on such children based on age.

The Committee bill further provides that State expenditures for first-time pregnant women, pregnant women in two-parent families, and children in two-parent families that qualify for the 100 percent Federal matching rate under the bill, are not to be held against a State for purposes of the current Federal matching penalty. The Committee bill provides that, for purposes of applying the percentage reduction penalty, State payments for services furnished to qualified pregnant women and children are to be disregarded in calculating the State's expenditures. In addition, under current law, States may reduce the Federal matching penalty they would experience in FY 1984 by limiting the growth in their Federal Medicaid expenditures below a target amount. The Committee bill provides that, for purposes of determining the State's Federal expenditures in relation to the target amount, payments for services furnished to qualified pregnant women and children are to be excluded from the calculation of the State's Federal Medicaid expenditures.

In view of the Committee, it would have been preferable to provide additional Federal funds to assist all States to assure that low-income children and pregnant women had medical coverage. But a

uniform increase in the Federal Medicaid matching rate in an amount sufficient to include these children and pregnant women was not possible within the budget constraints on the Committee. The Committee was therefore left with two choices for achieving its objective of extending coverage to this vulnerable group: either mandate State coverage, or allow those States that do not currently cover some or all of these groups to do so at Federal expense. While the Committee took the second approach, it also sought to acknowledge the efforts of those States that already cover these populations at their regular Medcaid matching rates by allowing them a modest, one-time bonus.

CURRENT MEDICAID COVERAGE

[As of June 30, 1983]

State	First-time pregnant women	Pregnant women in two-parent families with unemployed principal earner	All children in two-parent families	Federal medical matching rates (percent)
Alabama	X			72.14
Alaska	X		X	50
Arizona	NA	NA	NA	61.21
Arkansas			NA	73.65
California [2]	X	X	X	50
Colorado	X	X		50
Connecticut [2]	X	X	X	50
Delaware	X[3]	X		50
District of Columbia	X	X	X	50
Florida	X			58.41
Georgia	X			67.43
Hawaii	X	X		50
Idaho	X			67.28
Illinois	X	X		50
Indiana			X	59.93
Iowa	X	X	X	55.24
Kansas	X	X		50.67
Kentucky	X	X		70.72
Louisiana	X [4]			64.45
Maine		X	X	70.63
Maryland [2]	X	X	X	50
Massachusetts [2]	X	X	X	50.13
Michigan [2]	X	X	X	50.70
Minnesota [2]	X	X	X	52.67
Mississippi	X			77.63
Missouri	X		X	61.40
Montana	X			64.41
Nebraska	X	X		57.13
Nevada	X [4]			50
New Hampshire				59.45
New Jersey	X	X	X	50
New Mexico	X [4]			69.39
New York	X	X	X	50
North Carolina	X			69.54
North Dakota	X			61.32
Ohio	X	X		55.44
Oklahoma	X		X	58.47
Oregon	X [3]			57.12
Pennsylvania [2]	X	X	X	56.04
Rhode Island	X	X		58.17
South Carolina	X			73.51
South Dakota	X			68.31
Tennessee	X			70.66
Texas				54.37

CURRENT MEDICAID COVERAGE—Continued

[As of June 30, 1983]

State	First-time pregnant women	Pregnant women in two-parent families with unemployed principal earner	All children in two-parent families	Federal medical matching rates (percent)
Utah	X		X	70.84
Vermont [2]	X	X	X	69.37
Virginia				56.53
Washington	X	X		50
Weat Virginia	X	X		70.57
Wisconsin [2]	X	X	X	56.87
Wyoming	X			50

[1] As of Oct. 1, 1983. Source: Commerce Clearing House Medicare and Medicaid Guide, ¶14,905.
[2] Qualifies for ½ percentage point bonus.
[3] Medicaid coverage for 9th month pregnancy only.
[4] Medicaid coverage for third trimester of pregnancy only.

Source: Congressional Research Service table, Oct. 14, 1983.

Section 202. Prohibiting "deeming" of income and resources with respect to minor pregnant women

Under current law, States, in determining the Medicaid eligibility of children under 21, take into account the financial responsibility of the natural parents. Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, the Medicaid eligibility of a pregnant woman under 21 was premised on the eligibility of the unborn child. The income of the parents of a pregnant adolescent was not "deemed" to be available to the adolescent's unborn child, and therefore the adolescent and the unborn child could receive AFDC benefits and Medicaid. The change to pregnancy as the basis of categorical eligibility in P.L. 97-35 had the unintended result of denying Medicaid benefits to pregnant adolescents by defining the pregnant woman as the assistance unit and thereby "deeming" the parental income to the pregnant adolescent.

In the case of pregnant adolescents, the loss of Medicaid benefits resulting from this "deeming" of parental income, even when the adolescent has no private health insurance coverage, can work an unwarranted hardship. Young pregnant women may therefore be forced to go without proper medical care during the course of their pregnancy. This is a matter of particular concern to the Committee, because the incidence of low birthweight and infant mortality is very high among adolescent births, and because prenatal care has been shown to make a substantial contribution to reducing these adverse birth outcomes.

The Committee bill would allow States, at their option, not to "deem" the income or assets of the parents available to a pregnant woman under the age of 21 who does not have legal custody over other children, in determining eligibility for Medicaid. States could, at their option, apply this non-deeming policy to young pregnant women living with their parents, or to young pregnant women in a custodial institution for pregnant women, or to both. However, whatever policy the State adopted would have to be applied uniformly to all young pregnant women throughout the State; the State could not decide whether or not to "deem" parental income and assets on a case-by-case basis. The Committee amendment

would apply to Medicaid payments for calendar quarters on or after January 1, 1984.

Section 203. Clarification of medicaid entitlement for certain newborns

Under current law, States are required to provide Medicaid coverage to women and children receiving cash assistance benefits under the Aid to Families with Dependent Children (AFDC) program. In addition, States may cover those low-income women and dependent children who have too much income to qualify for AFDC but who can qualify as "medically needy" once their medical expenses are taken into account. It is the Committee's understanding that in many States, when a child is born to a woman who is eligible for Medicaid at the time of birth, the child is automatically assumed to be eligible for Medicaid, and appropriate payment is made to the hospital for the services provided to the child.

However, some States have established Medicaid application procedures that fail to provide for the automatic addition of a newborn child of a Medicaid beneficiary to that woman's family unit for purposes of Medicaid eligibility. As a result, the newborn remains technically ineligible for Medicaid until the mother applies for cash or medical assistance on the child's behalf, a process that may take a considerable amount of time, particularly if the woman required extended convalescence due to medical complications resulting from the birth.

The lack of automatic Medicaid coverage for the newborn places the hospital at financial risk and increases the likelihood that children born to Medicaid-eligible women will not have access to crucial neonatal care. The Committee is aware of at least one instance in a State with such a policy in which hospitals denied admission to Medicaid beneficiaries in labor in order to avoid having to care for the uncovered and potentially high-risk babies. This is a matter of grave concern to the Committee.

The Committee bill clarifies that a child born to a woman eligible for and receiving Medicaid at the time of birth is deemed to be eligible for Medicaid for one year, so long as the woman remains eligible for Mediciad and the child remains a member of the woman's household. This will give the woman a reasonable opportunity to make a personal application for Medicaid eligibility on the child's behalf. The child's deemed eligibility would end before the one year period if the mother lost her eligibility. However, as under current law, the State would have to give the mother and child reasonable and timely notice if it had made a determination that neither continued to qualify for Medicaid on a different basis.

PART B. MISCELLANEOUS MEDICAID CHANGES

Section 211. Medically needy income levels

Under current law, States have the option of extending Medicaid coverage to the "medically needy." These are low-income adults with dependent children, or aged, blind, or disabled individuals, who have the characteristics necessary to qualify for cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs, but whose

income or resources are too high to permit them to do. In order to receive Medicaid coverage under a State's medically needy program, an individual must "spend down" until his or her medical expenses, when applied against income for the relevant accounting period, reduce that income below the State-established medically needy income level.

The medically needy income level may not be set at a level higher than an amount equal to 133⅓ percent of the highest amount that would ordinarily be paid to an AFDC family of the same size without any income or resources. Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Federal guidelines allowed States to set the medically needy income levels for two adults at an amount equal to 133⅓ percent of the AFDC payment for a family of one adult and two children. (HCFA-ROM-31, June 19, 1979). This guideline recognized that a State could find that an adult had greater maintenance needs than a child, and could set its medically needy income level for two adults accordingly.

It is the understanding of the Committee that the Department of health and Human Services has reversed its policy on this point and taken the position that a medically needy income level for two adults could not, consistent with Federal law, be set at an amount equal to 133⅓ percent of the amount ordinarily paid to an AFDC family of three without income or resources. The Department's new policy appears to be that the medically needy income level for two adults may not be set higher than an amount equal to 133⅓ percent of the amount ordinarily paid to an AFDC family of two without income or resources.

The Committee bill would reinstate the Department's previous policy. States could, at their option, set the medically needy income level for two adults, one of whom is aged, blind, or disabled, at an amount no higher than 133⅓ percent of the highest amount that would ordinarily be paid to a family of one adult and two children without any income or resources under the State's AFDC plan.

The Committee is at a loss to understand why the Department has decided to alter its policy in this regard. The policy is sound; a State could quite logically determine that the maintenance needs of adults differ from those of dependent children. The Committee recognizes that the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, gave the States more flexibility with respect to the operation of their medically needy programs. The OBRA changes did not, however, extend to income and resource eligibility requirements for the medically needy. This was reaffirmed in the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, which attempted to reinstate the medically needy income and resource eligibility policies that had been in effect prior to the enactment of OBRA and that the Department had improperly attempted to alter by regulation. The TEFRA provisions, among other things, specified that States are to employ a single standard in determining income and resource eligibility for all groups that the State chooses to cover. The Committee bill makes clear that this single standard requirement does not justify a rejection of the valid 1979 policy with respect to two medically needy adults.

To avoid any further confusion on this point, the Committee provides the following hypothetical example of how its amendment would work. Assume that the highest AFDC cash payment is $300 per month in the case of a family of two with no income or resources and $400 per month in the case of a family of three with no income or resources. The State could set its medically needy income level for two adults, one of whom was aged, blind, or disabled, at a level no higher than 133⅓ percent of $400, or $533.32 per month. The State could, of course, set its medically needy income level for two adults at a lower level, say, 133⅓ percent of the $300 payment to an AFDC family of two, or $400 per month. If the State set its medically needy income level for two adults at $400, the income level for AFDC-related medically needy families would have to be the same. If the State chose to set its medically needy income level for two adults above $400 (subject to the $532 per month ceiling), the medically needy income level for a two-person AFDC-related family would have to be set at $400. Medically needy income levels for three-person AFDC-related families would be determined as under previous law. In short, the Committee amendment would relax the single standard requirement only in the limited circumstance in which a State sets its medically needy income level for two adults in excess of 133⅓ percent of the highest cash payment ordinarily made to a family of two under the State's AFDC program.

Section 212. Recertification of need for stays in skilled nursing and intermediate care facilities

Under current law, States are required to make a showing satisfactory to the Secretary that each Medicaid patient in a skilled nursing facility (SNF) and intermediate care facility (ICF) is certified as needing the level of services provided in that facility. This certification must occur at the time of admission to the facility (or at the time of initial application for Medicaid, if later) and at least every 60 days thereafter. The certification must be performed by a physician or, at the State's option, by a physician assistant or nurse practitioner under the supervision of a physician.

In order to validate a State's showing, the secretary conducts sample on-site surveys of patient records in nursing homes participating in Medicaid in that State. Failure by a State to document timely recertifications with respect to either SNF or ICF patients results in a reduction in the Federal medical assistance percentage for the applicable SNF or ICF expenditures for the calendar quarter. The reduction is a percentage equal to 33⅓ percent times the ratio of (1) the number of SNF or ICF patients in those facilities for which a satisfactory and valid showing was not made for the quarter to (2) the total number of SNF or ICF patients in the State for that quarter.

While the Committee continues to believe that effective utilization controls on Medicaid SNF and ICF services are needed for the protection of both the patients and the taxpayer dollar, the Committee is concerned that the 60-day recertification requirement with respect to ICF patients is unnecessarily rigid, and that the current penalty for noncompliance with these recertification requirements is too stringent. The Committee bill establishes a more

reasonable set of requirements for ICF services that will give the States an incentive to avoid unnecessary utilization without being unduly burdensome.

Under the Committee bill, the recertification of need requirement would be altered as follows. In the case of ICF patients, recertifications would have to occur on or before 60 days after admission, 6, 12, 18, and 24 months after admission, and annually thereafter. In the case of SNF patients, recertifications would have to occur on or before 30, 60, and 90 days after admission, and every 60 days thereafter. (The annual recertification requirement for patients in ICFs for the mentally retarded would not be affected by the Committee bill). Recertifications are to be considered as timely if performed not later than 10 days after a deadline if the State can demonstrate that the physician had good cause for missing the deadline. These new recertification schedules apply to ICF patients beginning on January 1, 1984, and to SNF patients admitted after that date.

The Committee bill also alters the current penalty formula for noncompliance with the recertification requirements. (The current formula would continue to apply with regard to the "inspections of care" requirement). States which cannot demonstrate compliance with the recertification requirements would be subject to a percentage reduction in their Federal medical assistance percentage equal to 5 percent times the ratio of (1) the number of patients receiving SNF or ICF services whose records were found by the Secretary through the sample onsite surveys for a calendar quarter not to comply, to (2) the total number of patients receiving SNF or ICF services whose records were included in the onsite surveys conducted that quarter. When this ratio is 3 percent or less, no penalty would apply.

The Committee bill also reaffirms the Secretary's duty to assure that Medicaid patients in SNFs and ICFs receive appropriate, high quality care. A United States District Court has recently held that the Secretary of Health and Human Services has the authority, but lacks the duty, to assure that nursing homes participating in the Medicaid program provide care consistent with the individual needs of their Medicaid patients. *In Re Estate of Smith v. O'Halloran,* 557 F. Supp. 289 (D. Colo. 1983). The Committee believes that under existing Medicaid law, the Secretary has such a duty, and it reaffirms and clarifies that duty here.

Under the Committee bill, the Secretary must assure that the standards which govern the provision of care to Medicaid patients in SNFs and ICFs, and the enforcement of those standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys. The Committee notes that a fundamental purpose of the Medicaid statute is to help individuals attain or retain capability for independence and self care. The Committee believes that the Secretary has the responsibility to devise, and require all States to implement, effective standards and enforcement systems which achieve that purpose by assuring that nursing home residents eligible for Medicaid receive appropriate, high quality services.

Section 213. Waiver of certain membership requirements for certain health maintenance organizations

Under current law, health maintenance organizations and other prepaid plans may not deliver services to Medicaid beneficiaries on a prepaid capitation or other risk basis unless no more than 75 percent of the prepaid enrolled membership of the HMO or plan is eligible for Medicaid or Medicare. The Secretary is authorized to waive this requirement in the case of public HMO's if she determines that (1) special circumstances warrant such modification or waiver, and (2) the organization has made, and continues to make, reasonable efforts to enroll members who are not Medicare or Medicaid beneficiaries.

In the view of the Committee, the requirement that one out of four of the enrollees of an HMO or prepaid paln be a private patient is absolutely essential to the assurance of adequate quality of care under such prepayment arrangements, where the economic incentives to underserve are strong. An organization that cannot persuade members or private or public employee groups to enroll in significant numbers faces a strong presumption that it is not qualified to serve public patients either. The Committee recognizes, however, that there may be certain circumstances where it is simply not possible for an HMO or prepaid plan to find sufficient numbers of non-Medicare and non-Medicaid patients, despite extensive marketing efforts. Current law already allows public entities to seek a waiver of this requirement. The Committee bill would give the Secretary additional waiver authority to accommodate the small number of cases where private HMOs or prepaid plans, despite extensive efforts, have been unable to enroll a sufficient number of non-Medicare and non-Medicaid patients, and where the quality of care is not compromised as a result.

Under the Committee bill, the Secretary may modify or waive the 75 percent Medicare and Medicaid enrollment limitation in the case of an HMO that (1) is nonprofit, (2) has at least 25,000 members, (3) is and has for at least four years been a Federally-qualified HMO under section 1310(d) of the Public Health Service Act, (4) provides basic health services through its staff, (5) is located in a medically underserved area, and (6) previously received a waiver of the 75 percent limitation under section 1115 of the Social Security Act. The Secretary may grant a waiver only if she determines that special circumstances so warrant and that the HMO is making reasonable efforts to enroll individuals other than those eligible for Medicare and Medicaid. The Committee intends that the Secretary exercise this waiver authority in those instances where an HMO meeting the waiver requirements has a service area in which the population consists predominantly of Medicaid eligibles, already has a membership composed almost totally of Medicaid beneficiaries, is being actively encouraged by the State Medicaid agency to enroll even more Medicaid-eligible members, and faces a market in which the major private employers are highly selective in their offering of HMOs.

Section 214. Prohibiting medicaid copayments for prescribed drugs

Under current law, States are permitted to impose nominal copayments on most covered services with respect to most categories of Medicaid beneficiares. However, States may not impose copayments on services furnished to pregnant women, to children under 18, to inpatients in nursing homes and other institutions who are required to spend all but a minimum amount of their income on medical care, or to HMO enrollees. In addition, States may not impose copayments on emergency service or family planning services and supplies.

When a State chooses to impose copayments, the provider is usually responsible for collecting the required amount. States will commonly reduce their reimbursement to participating providers by the amount of the required copayment. The beneficiary is liable for the required copayment. However, the provider may not deny care or services to the beneficiary if he or she is unable to pay the required copayment. The beneficiary remains liable for the copayment and may be subject to collecton action, including litigation, if necessary to secure payment.

The Committee understands that 17 States and the District of Columbia now impose copayments on perscription drugs. (The States are: Alabama, California, Iowa, Kansas, Maine, Michigan, Missiouri, Montana, Nevada, New Hampshre, North Carolina, South Carolina, South Dakota, Vermont, Virginia, West Virginia, and Wisconsin). These copayments range from 50 cents to $3.00 per prescription. In most cases, the amount of the copayments is deducted from the dispensing fee paid to independent pharmacists and chain drug stores for filling the prescriptions of Medicaid patients.

The Committee is concerned by the administrative and financial burdens that current copayment requirements impose on independent pharmacists and chain drug stores. Medicaid patients are by definition indigent, and many of them simply cannot afford the required copayments, particularly if they require multiple prescriptions. Moreover, it is virtually impossible, as a practical matter, for a pharmacist to determine whether a beneficiary is unable to pay while he or she is standing in line waiting for a prescription to be filled. Efforts to collect these amounts from the beneficiaries are extremely costly. While the individual copayments may be small, in the aggregate the loss in reimbursement for independent pharmacists and chain drug stores can be quite large, particularly in those stores located in poor neighborhoods and serving large numbers of Medicaid patients.

The Committee sees no justification for continuing to impose this burden on local pharmacists. The classic rationale for copayments—reduction in the unnecessary use of services—has no application in the case of precription drugs. The patient does not decide whether a prescription is necessary, a physician does. The patient is expected to follow the physician's instructions by securing and taking the drug. The pharmacist simply fills the prescription. To the extent that utilization controls are required for prescription drugs, they should apply to the physician's prescribing decision, not to the patient or the pharmacist.

The Committee bill deletes the authority of States to impose co-payments on prescription drugs with respect to any group of Medicaid beneficiaries. The provision is generally effective January 1, 1984. In those States where the Secretary finds that legislative action is required to make the necessary State Medicaid plan changes, the effective date is July 1, 1984.

Section 215. Maximum amount of medicaid payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa

Under current law, certain jurisdictions are subject to fixed statutory ceilings on the amount of Federal Medicaid matching funds they are eligible to receive. These jurisdictions, and the ceilings that currently apply are: Puerto Rico ($45 million); Virgin Islands ($1.5 million); Guam ($1.4 million); Northern Mariana Islands ($350,000); and American Samoa ($750,000). These ceilings are not adjusted to accommodate the effects of inflation on the price of health care services.

In the view of the Committee, an adjustment of these ceilings is long overdue. The Committee bill establishes new ceilings on Federal Medicaid matching payments for each of these jurisdictions as follows: Puerto Rico ($77.1 million); Virgin Islands ($2.6 million); Guam ($2.4 million); Northern Mariana Islands ($600,000); and American Samoa ($1.3 million). The amendment is effective on beginning with FY 1984.

Section 216. Payment for psychiatric hospital services

Under current law, Medicaid patients who need skilled nursing or intermediate facility care, but who are waiting in a hospital for placement in a nursing home, are subject to different reimbursement rules than those who need an acute inpatient hospital services. If the Secretary determines that the hospital has no excess beds, and if there are no excess hospital beds in the hospital's service area, the reimbursement for patients awaiting nursing home placement is set at the hospital's acute care rate; otherwise, Medicaid reimbursement must reflect the level of care actually received by the patient.

The application of this policy to public psychiatric hospitals in New Jersey has created a unique problem for the State and some of its localities. After July 1, 1984, reimbursement for Medicaid patients in these facilities awaiting nursing home placement will no longer be set at the acute care rate, but will be lowered to the skilled nursing facility rate. This will result in a sudden drop in the Medicaid reimbursement rate to the affected facilities by as much as 50 percent.

The Committee does not believe that it is reasonable to impose a reimbursement reduction on these facilities in such a precipitous manner, and that a gradual phase-in of current policy would be far more appropriate. The Committee bill therefore delays until July 1, 1985, the application of any reimbursement reductions required to be made to public psychiatric hospitals due to the level of care received by Medicaid patients in such hospital. The bill further requires that one third of the reductions take effect during the year

ending June 30, 1986, and that the remaining two-thirds of the reductions take effect during the year ending June 30, 1987.

Title III—Recovery of Hill-Burton Funds

Section 301. Recovery of Hill-Burton Funds

Since the enactment of the Hill-Burton program in 1946, the Federal government has invested approximately $5.9 billion in public and private nonprofit hospitals and other health care facilities through grants, direct loans, and loan guarantees for construction or modernization. Under both the original Hill-Burton legislation, found at Title VI of the Public Health Service Act, and the successor resources development authority found at Title XVI of the Public Health Service Act, the Federal Health Service Act, the Federal government is entitled to recover its interest in a Hill-Burton facility if the facility (1) is sold or transferred to a proprietary entity or (2) undergoes a change in use from that for the assistance was originally provided.

This Federal right of recovery exists for twenty years from the date of completion of the assisted construction or modernization project. The Secretary is authorized to waive recovery for good cause in certain limited circumstances. The amount of the recovery is a percentage of the value of the assisted protions of the facility at the time of sale, transfer, or change in use. The percentage is the ratio of the amount of Federal assistance to the total cost of the construction or modernization project. The value of the facility at the time of sale, transfer or change in use is determined either by an agreement of the Secretary of Health and Human Services and the owners of the facility, or by a U.S. District Court. The Federal recovery right does not constitute a lien upon a Hill-Burton facility prior to judgment.

On April 30, 1982, the Comptroller General released a report on the administration of the Hill-Burton program by the Department of Health and Human Services. The report had been requested jointly by the Subcommittee on Health and Environment and the Subcommittee on Oversight and Investigations in September, 1981. With respect to the Federal recovery right, the General Accounting Office noted a number of significant deficiencies in the Department's recovery process, including the lack of reliable, timely information on the occurrence of a sale, transfer, or change in use in the roughly 5,000 Hill-Burton facilities in which the Federal government still has a potential recovery interest.

The Comptroller General also referred the Committee to the findings of the Inspector General of the Department of Health and Human Services, who was at that time conducing an extensive audit of the Department's Hill-Burton recovery activities. That audit, completed in September, 1982, found that the Federal government was sustaining substantial avoidable financial losses because the recovery program was not effectively administered. According to the audit, facility status changes that would trigger the Federal recovery right were not being promptly identified; recoveries were not being consummated in a timely fashion; and recovery amounts, once determined, were inequitable to the Federal taxpayers and were, in some cases, never collected.

The Committee is deeply disturbed by the findings of both the Comptroller General and the Inspector General. The Committee recognizes that, in response to these investigations, the Department has taken some long-overdue corrective measures. The Committee expects that the Department will continue to make every effort to improve its administration of the Hill-Burton program. However, the Committee believes that, in addition to improved administrative performance, the underlying statutory scheme must be tightened if the Federal recovery right is to be properly protected.

The Committee bill makes three changes in current law designed to safeguard the Federal financial investment in Hill-Burton facilities. First, the bill requires that, in the case of Hill-Burton facilities sold or transferred or subject to a change in use after the date of enactment, the transferor or owner of the facility give the Secretary written notice of the sale, transfer, or change in use not later than 10 days from the date of the sale, transfer, or change in use. Failure to provide the required notice will result in the imposition of an interest penalty on the recovery amount at a rate based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate. The interest penalty would begin to accrue on the date of the sale, transfer, or change in use, and would continue until the Federal government had collected the full amount of the recovery and the interest penalty.

Secondly, the Committee bill creates an incentive for owners or transferors of Hill-Burton facilities to reach an agreement with the Federal government as to the amount of recovery and to pay the required amount within a reasonable period of time. The Inspector General's audit found that in a significant number of cases the absence of a fixed time frame for negotiations resulted in unnecessary delays on consummating the Federal recovery, and that the prospect of an interest penalty would help to alleviate this problem. Thus, in the case of facilities that are sold or transferred, or that experience a change in use after the date of enactment, the Committee bill allows 6 months within which to agree upon and pay the recovery amount. Thereafter, interest would begin to accrue at a rate based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate, and would continue to apply until the recovery amount, plus all interest owed, had been collected by the Federal government.

The Committee believes that this 6-month time frame will give Hill-Burton facilities more than ample time to conclude the recovery negotiations and satisfy their obligations without incurring any interest penalty.

In the case of facilities that were sold or transferred, or that underwent a change in use before the date of enactment the same interest penalty would begin to accrue if the recovery had not been agreed to and paid by July 1, 1984. This time frame applies both to facilities involved in sales, transfers, or changes in use of which the Department is aware, and to those facilities with regard to which the Department is currently unaware that its recovery interest has arisen. In either case, the interest penalty will begin to accrue on July 1, 1984, and will run until the recovery amount has been determined and paid, plus interest, to the Federal government. The Committee believes that July 1, 1984, deadline will allow more

than enough time for those facilities with respect to which recoveries are now pending to conclude their negotiations with the Department and satisfy their recovery obligation.

The Committee notes in passing that the Hill-Burton Act contains no limit on the period during which the Federal government can seek to recover funds, and that no other statute of limitation applies to Hill-Burton recovery actions. It is the Committee's specific intent that the United States continue to be allowed to seek recovery under the Hill-Burton Act at any time after the right to recovery has arisen. *U.S.* v. *City of Palm Beach Gardens,* 635 F.2d 337 (5th Cir. 1981). The fact that the Department of Health and Human Services is not aware that a Hill-Burton facility has, within 20 years of completion of construction, been sold, been transferred, or undergone a change in use, does not extinguish the Federal recovery right.

Finally, the Committee bill provides that the right of recovery shall constitute a lien on any Hill-Burton facility. Of course, the Federal government could not foreclose upon such a lien unless the right of recovery had been triggered by a sale, transfer, or change in use within 20 years of the date of completion of construction. However, the imposition of a lien will assure that the cases of nonrecovery of Federal funds identified by the Inspector General's audit will not recur, and that the Federal financial interest will be completely protected from both a legal and practical standpoint.

The Committee bill also clarifies the long-standing statutory policy that the Secretary is authorized to waive recovery for good cause (in accordance with regulations) only in cases where there has been a change in use—that is, where a Hill-Burton facility ceases to be a public health center or public or private nonprofit hospital, outpatient facility, long-term care facility, or rehabilitation facility—not where a facility has changed its sponsorship from public or private nonprofit to proprietary. There has apparently been some unnecessary confusion on this point. *U.S.* v. *First Georgia Bank and Beverly Enterprises,* 529 F. Supp. 384 (N.D. Ga., 1982). Of course, facilities for which waivers of recovery are granted under the change in use provision remain subject to the uncompensated services and community service assurances that they gave in exchange for Hill-Burton funds. Finally, the Committee bill also conforms the standard for waiver of recovery under Title XVI of the Public Health Service Act with that in Title VI, to assure consistency of administration.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Subcommittee on Health and the Environment held oversight hearings and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the provisions of Titles I and III of H.R. 4136 relating to Medicare and Recovery of Hill-Burton funds would result in reductions in Federal outlays in the amount of $184 million in fiscal year 1984, $373 million in fiscal year 1985, and $445 million in fiscal year 1986, for a three year total of $1,002 million. The Committee believes that the provisions of Title II of H.R. 4136 relating to Medicaid would result in additional Federal outlays of $162 million in fiscal year 1984, $229 million in fiscal year 1985, and $308 million in fiscal year 1986, for a three year total of $669 million. The Committee believes that, in the long run, the outlays for prenatal and delivery services to low-income pregnant women, and for preventive services for low-income infants and young children, will be more than offset by savings in the form of reduced institutional care.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. Congress,
Congressional Budget Office,
Washington, D.C., October 25, 1983.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for the Medicare and Medicaid Budget Reconciliation Amendments of 1983, as ordered reported by the House Energy and Commerce Committee on October 19, 1983.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

Rudolph G. Penner,
Director.

Congressional Budget Office—Cost Estimate

1. Bill number: H.R. 4136.
2. Bill title: The Medicare and Medicaid Budget Reconciliation Amendments of 1983.
3. Bill status: As ordered reported by the House Committee on Energy and Commerce, October 19, 1983.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide for reconciliation savings and other changes with respect to the Medicare program, to amend title XIX of such Act to increase the federal medical assistance matching percentage for services provided to certain pregnant women and young children under state Medicaid plans, and for other purposes.
5. Estimated cost to the Federal Government: The section below shows only the sections that have a budgetary impact.

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988
Title I—Medicare:					
Clinical labs (section 101) outlays	−150	−350	−425	−500	−600
Hepatitis (section 102) outlays	2	−1	−2	−2	−4
Limitation on certain foot care (section 107) outlays	−28	−40	−42	−45	−48
Title II—Medicaid:					
Child health assurance program (section 201–203) outlays	120	160	240	640	770
Medically needy (section 211) outlays	20	29	31	34	37
Recertification of nursing home care (section 212) outlays	−8	−1	.....	1	1
Prohibiting medical copayments for prescribed drugs (section 214) outlays	10	23	25	28	30
Increase maximum Medicaid for territories (section 215) outlays	35	35	35	35	35
Payment for psychiatric hospitals (section 216) outlays	10	10	6	3	.....
Title III: Hill-Burton funds outlays	−15	−20	−20	−10	−10
Other:					
Impact of medicare proposals on medicaid outlays	−20	−25	−30	−35	−40
Impact of medicare proposals on premiums outlays	27	63	74	75	77
Impact of medicaid proposals on medicare outlays	−25	−27	−29	−31	−33
Total:					
Budget authority	−35	−112	−101	220	238
Outlays	−22	−144	−137	193	215

The costs of this bill fall within budget functions 550 and 570.

6. Estimated cost to State and local governments: Changes to Medicare affect Medicaid spending since about 15 percent of those covered by Medicare are also covered by Medicaid. In addition, the changes to the federal Medicaid program would also affect state and local spending. Changes in estimated state and local Medicaid spending are shown below.

[By fiscal year; in millions of dollars]

	1984	1985	1986	1987	1988
Estimated changes in State and local spending in medicaid	−61	14	17	21	23

The clinical lab proposal would reduce Medicare expenditures to providers and save money in both Medicare and Medicaid programs. Increasing the Medically Needy standards and prohibiting copayments for prescription drugs under the Medicaid program would increase state and local expenditures. The Child Health amendments would save money by reducing the penalties for some of the states. In addition, federal funds provided under this bill may defray current state expenditures for the health care of this population. However, we are unable to estimate this budget impact on state and local governments.

7. Estimated comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Diane Burnside and Hinda Ripps Chaikind.

10. Estimate approved by James L. Blum, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statements with regard to the inflationary impact of H.R. 4136.

The Committee believes that the bill will reduce Federal outlays for certain services covered under the Medicare program, including outpatient diagnostic laboratory tests. In this regard, the Committee bill may reduce prices for such services, although the Committee does not anticipate that the bill will have any measurable effect on health care prices or consumer prices generally. The additional public expenditures for maternal and child health services provided for under the bill are extremely small relative to current total health care expenditures and the Federal budget. Therefore, the effect of these expenditures on demand for health services and on the Federal budget is minimal.

SECTION-BY-SECTION ANALYSIS

Section 1

The first section contains the short title of the bill, "Medicare and Medicaid Budget Reconciliation Amendments of 1983". The section also contains the table of contents.

Title I—Medicare Reconciliation Amendments

PART A. PAYMENT—AND COVERAGE-RELATED CHANGES

Section 101. Payment for outpatient diagnostic laboratory tests

Section 101(a) amends Section 1833(a) of the Social Security Act as follows:

Section 101(a)(1) amends clause D of subsection (a)(1) to specify that payment for diagnostic laboratory tests shall be equal to 80 percent of the lesser of the fee schedule amount established under the new subsection (h) or the amount of billed charges. If payment is made on the basis of assignment or under the procedure established under section 1870 (f)(1) (relating to payment in behalf of deceased beneficiaries), payment shall be equal to 100 percent of the lesser of the fee schedule amount or the billed charges.

(2), (3), and (4) make conforming changes.

(5) adds a new subparagraph (2)(D) which specifies that Part B payment for diagnostic laboratory tests shall be 100 percent of the lesser of the fee schedule amount under new subsection (h) or the billed charges.

Section 101(b) amends Section 1833(b) by adding a new paragraph (4) which specifies that the Part B deductible does not apply to diagnostic laboratory tests which are paid on the basis of assignment or under the procedure established under Section 1870(f)(1) (relating to payment in behalf of deceased beneficiaries) or to a provider of services which has an agreement with the Secretary under Section 1866.

Section 101(c) amends Section 1833(h) of the Social Security Act as follows:

New Section 1833(h)(1) requires the Secretary to establish a national fee schedule for diagnostic laboratory tests paid for under Part B.

(2) provides that except as provided in paragraph (4), the Secretary shall set the fee schedule at 60 percent of the prevailing charges paid under Part B for similiar diagnostic laboratory tests during the fee screen year beginning July 1, 1983, adjusted annually to reflect changes in the Consumer Price Index for All Urban Consumers (U.S. city average) and subject to such other adjustment as the Secretary determines are justified by technological changes.

(3) specifies that, addition to the fee schedule amounts, the Secretary is required to provide for and establish a nominal feel to cover the costs in collecting the sample. Not more than one such fee may be provided for samples collected in the same encounter.

(4)(A) specifies that during the three-year period beginning March 1, 1984, the Secretary may establish the fee schedule on a regional or Statewide basis if he determines that a national fee schedule is inappropriate at such time because of limitations in the available data.

(B) permits the Secretary to make regional or local wage adjustments in the fee schedule.

(5)(A) specifies that no payment may be made to a physician for a diagnostic laboratory test unless the physician (or another physician with whom the physician shares his practice) personally performed or supervised the performance of the test.

(B) specifies that payment for a diagnostic lab test performed by a laboratory which is independent of a physicians' office or a rural health clinic may only be made on the basis of assignment, under the procedure described in Section 1870(f)(1), or to a provider of services which has an agreement with the Secretary.

Section 101(d) repeals Section 1842(h) of the Social Security Act.

Section 101(e) amends Section 1866(a)(2)(A) of the Act to prohibit providers from imposing coinsurance charges with respect to diagnostic laboratory tests.

Section 101(f)(1) amends Section 1902(a) of the Social Security Act by deleting paragraph (43) relating to reimbursement for laboratory services under Medicaid.

(2) adds a New Section 1903(i)(7) to Act.

New Section 1903(i)(7) specifies that payment may not be made under Medicaid with respect to diagnostic laboratory tests performed by a physician, independent laboratory, or hospital (other than for an inpatient of the hospital), to the extent such amount exceeds the fee schedule amount payable under Medicare.

Section 101(g) requires the Secretary of Health and Human Services to simplify the procedures under section 1842 of the Social Security Act with respect to claims and payments for diagnostic laboratory tests under part B.

Section 101(h) specifies that the amendments made by Section 101 shall be effective March 1, 1984 except for the provision pertaining to Medicaid which is effective for calendar quarters beginning on or after April 1, 1984.

Section 102. Coverage of administration of hepatitis B vaccine

Section 102(a) adds a subparagraph B to Section 1861(5)(10) of the Social Security Act.

New Section 1861(5)(10)(B) adds coverage for hepatitis B vaccine and its administration when furnished in a hospital or a renal dialysis facility.

Section 102(b) amends Section 1833 by adding a new subsection (K).

New Section 1833(K) authorizes the Secretary to provide for payment (in lieu of payment otherwise provided for) of an amount or amounts which reasonably reflect the cost of efficiently providing the new service.

Section 102(c) specifies that the amendment made by section 102 is effective for services furnished on or after January 1, 1984.

Section 103. Part B payment for services of teaching physicians

Section 103(a) amends Section 1842(b)(6)(B) of the Social Security Act pertaining to payment for Part B payment for services of a teaching physician as follows:

(1) and (2) limit, for purposes of customary charge determinations, the consideration of charges made by a physician outside the teaching setting to physicians who are not teaching physicians.

(3) makes a conforming change.

(4) specifies that payment for services of teaching physicians shall be based on the greater of items specified in subclause I, II, or the new subclause III.

(5) and (6) make conforming changes.

(7) adds a new subclause III which includes the 75th percentile of prevailing charges paid for similar services in the locality as an item to be considered when payment amounts for teaching physicians are established.

(8) adds a new clause (iii) to Section 1842(b)(6))(B) to specify that if all the teaching physicians in the hospital agree to have payment made for all physicians' services under Part B furnished patients in the hospital on the basis of an assignment or under the procedure described in section 1870(f)(1), the carrier shall take into account the amounts otherwise payable under Part B with respect to similar services in the same locality.

Section 103(b) specifies that the amendments made by Section 103 shall apply to services furnished on or after July 1, 1984.

Section 104. Information on physician assignment practices

Section 104 amends Section 1842 to add the following new subsections:

New Section 1842(i)(1) requires the Secretary to compile annually a list of physicians serving individuals enrolled under Part B indicating the share (by percentile intervals not to exceed quartiles) of claims which each physician has accepted on an assignment basis or has had payment made under the procedure described in section 1870(f)(1) in the preceding year.

(2) requires the Secretary to make available in each office of the Social Security Administration the information compiled under paragraph (1) for the local geographic area served by the office no

more than six months after the end of each year and, upon request, by mail from each carrier. The Secretary is required, when such information becomes available, to notify annually each individual enrolled under Part B of the availability of such information.

New Section 1842(j)(1) requires the Secretary to publish annually a list of all physicians who have agreed to accept payment under Part B on the basis of an assignment or under the procedure described in section 1870(f)(1) for all services furnished under Part B during the following twelve-month period to enrolled individuals.

(2) provides that in order to permit the publishing of the list provided for under paragraph (1), the Secretary is required annually, before the beginning of the twelve-month period, to offer physicians a reasonable opportunity to sign an agreement that they will accept payment under Part B on the basis of an assignment or under the procedure described in section 1870(f)(1) for all services furnished under Part B during the following twelve-month period to enrolled individuals.

(3) requires the Secretary to provide annually to each individual enrolled under Part B and residing in a local geographic area notice of the availability of the list of all physicians in that area who have signed such an agreement for the following twelve-month period.

Section 105. Study of medicare part B payment

Section 105(a)(1) requires the Secretary of Health and Human Services to study and report to Congress, no later than December 30, 1984, on methods by which payment amounts and other program policies under Part B of Medicare may be modified:

(A) to eliminate inequities in the relative amounts paid to physicians by type of service, locality, and specialty, with particular attention to any inequities between cognitive services and medical procedures;

(B) to increase incentives for physicians and other suppliers under such part to accept assignment for Medicare services; and

(C) to provide incentives for physicians and other providers not to provide increased or otherwise excessive amounts of hospital, physician, and other health care services.

(2) requires the Secretary, in carrying out the study, to take into account the relative time, complexity, investment in professional training, and overhead expenses necessary to the provision of various medical services and procedures.

(3) provides that the report must include a description of one or more national or regional fee schedules for payments under part B which are consistent with the findings of the study.

Section 105(b) provides that in order to carry out the study and facilitate Congressional review, the Secretary must compile a centralized Medicare Part B charge data base, utilizing information gathered by the Medicare carriers and used by them in making the 1984 reasonable charge updates. Such data shall include information, by procedure, on:

(1) utilization,

(2) assignment rates of physicians and suppliers,

(3) actual, customary, and prevailing charges, and

(4) the differences in charges by physician specialty and locality.

Section 105(c) requires the Secretary to include recommendations for legislative amendment necessary to implement the findings and recommendations of the study.

Section 105(d) provides that in preparing the report and recommendations, the Secretary shall consult, as appropriate, with national organizations of physicians and other interested associations and individuals.

Section 106. Pacemaker reimbursement review and reform

Section 106(a)(1) requires the Secretary to issue revisions to the current guidelines for the payment under Part B of title XVIII of the Social Security Act for the transtelephonic monitoring of cardiac pacemakers. The revised guidelines must include provisons regarding the specifications for and frequency of transtelephonic monitoring procedures which will be found to be reasonable and necessary.

(2)(A) provides that if the revised guidelines have not been issued and put into effect by February 1, 1984, payment may not be made under Part B of title XVIII of Social Security Act for transtelephonic monitoring procedures (with respect to a single-chamber cardiac pacemaker powered by lithium batteries) conducted more frequently than:

(1) weekly during the first month of implantation,

(2) once every two months during the period representing 80 percent of the estimated life of the implanted device, and

(3) monthly thereafter.

(B) specifies that the limits under Paragraph A only apply to the monitoring of single-chamber cardiac pacemaker devices powered by lithium batteries. Further, the limits shall not apply in cases where the Secretary (or the Secretary's agent) determines that special medical factors (including possible evidence of pacemaker malfunction) justify more frequent transtelephonic monitoring procedures.

Section 106(b)(1) requires the Secretary to review, and report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate, regarding the appropriateness of the current rate of reimbursement under Part B for physicians' services associated with implantation or replacement of pacemaker devices and pacemaker leads. Such review must take into account the amounts recognized as reasonable with respect to such procedures and the time and difficulty of such procedures at the current time in comparison with such amounts and the time and difficulty of such procedures at the time the rates for such procedures were first established. In making such review and report, the Secretary must take into consideration and reduction of such recognized rates by 20 percent.

(2) requires the Secretary to complete the review by April 1, 1984.

Section 106(c) adds a new subsection (g) to Section 1866 of the Social Security Act.

New Section 1866(g)(1) requires the Secretary, through the Commissioner of the Food and Drug Administration to provide for a

registry of all cardiac pacemaker devices and pacemaker leads for which payment was made under Medicare. Such registry must include the manufacturer, model, serial number, and manufacturer's price of each such device or lead, the name of the recipient of such device or lead, the date and location of the implantation or removal of the device or lead, the name of the physician involved in implanting or removing such device or lead, the name of the hospital or other provider billing for such procedure, any express or implied warranties associated with such device or lead under contract or State law, and such other information as the Secretary deems to be appropriate. Such registry must be for the purposes of assisting the Secretary in determining when payments may properly be made under Medicare; in determining when inspection by the Food and Drug Administration may be necessary and, in carrying out studies with respect to the use of such devices and leads. In carrying out any such study, the Secretary is prohibited from revealing any specific information which identifies any pacemaker device or lead recipient by name (or which would otherwise identify a specific recipient). The section further provides that any person or organization may provide information to the registry with respect to cardiac pacemaker devices and leads other than those for which payment is made under Medicare.

(2) provides that in any case where the Secretary has reason to believe, based upon information in the pacemaker registry or otherwise available to him, that replacement of a cardiac pacemaker device or lead for which payment is or may be requested under Medicare is related to the malfunction of a defice or lead, the Secretary may require that personnel of the Food and Drug Administration test such device, or be present at the testing of such device by the manufacturer, to determine whether such device was functioning properly.

Section 107. Payment for debridement of mycotic toenails

Section 107 precludes payment under Part B for a physician's debridement of mycotic toenails to the extent such debridements is performed for a patient more frequently than once every 60 days, unless the medical necessity for more frequent treatment is documented by the billing physician.

PART B. MISCELLANEOUS ADMINISTRATIVE CHANGES

section 111. Repeal of special tuberculosis treatment requirements and requirement of accreditation for psychiatric hospitals

Section 111(a) amends Section 1814(a) of the Social Security Act by deleting special tuberculosis treatment references.

Section 111(b) amends Section 1861 of the Social Security Act by deleting special tuberculosis treatment references and deletes the requirement for JCAH accreditation of psychiatric hospitals.

Section 111(c) amends Section 1863 of the Act to delete special tuberculosis treatment reference.

Section 111(d) amends Section 1866 of the Act to delete special tuberculosis treatment references.

Section 111(e) amends Section 1902(a)(28) by deleting special tuberculosis treatment reference.

Section 111(f) amends Section 1903(g)(1) by deleting special tuberculosis treatment reference.

Section 111(g) amends Section 1905(a) of the Act by deleting special tuberculosis treatment reference.

Section 112. Indirect payment of supplementary medical insurance benefits

Section 112(a) amends Section 1842(b)(5) of the Social Security Act by adding a new clause B. Under this clause, Part B payments may be made to an entity: (1) which provides coverage of Part B services under a health benefits plan, but only to the extent that payment is not made under Part B; (2) which has paid the person who provided the service an amount (including the amount payable under Part B which that person has accepted as payment in full for the service; and (3) to which the individual has agreed in writing that payment may be made under Part B.

Section 112(b) makes a conforming change.

Section 113. Medicare recovery against certain third parties

Section 113(a) amends Section 1862(b)(1) of the Social Security Act by providing that Medicare payments are conditional on the recovery by the United States of the amounts owed by liable third parties. The section provides that the United States may recover amounts owed from liable third parties by: (1) bringing an action against the entity responsible for payment (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment); (2) bringing an action against the entity to which payment has been so made (if the entity is other that the individual entitled to benefits under this title); or (3) joining or intervening in any action related to the events that gave rise to the need for the item or service. The Section specifies that the United States shall be subrogated (to the extent of the payment under Medicare) to any right of the individual or any other entity to payment.

Section 113(b) amends Section 1862(b)(2)(B) of the Social Security Act by applying the same Medicare recovery and subrogation rights with respect to services provided to renal disease patients covered under a group health insurance plan during the period when such policy is the primary payer.

Section 113(c) amends Section 1862(b)(3) of the Social Security Act by applying the same Medicare recovery and subrogation rights with respect to services provided to the working aged covered under a group health insurance plan during the period when such policy is the primary prayer.

Section 114. Termination of agreement with institutions and entities where owners or certain other individuals have been convicted of certain offenses

Section 114 amends Section 1866(b)(2)(G) of the Social Security Act by extending the Secretary's authority to terminate a provider's Medicare participation. The provision specifies that a provider may be terminated if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee, has been

convicted of a criminal offense related to participation in Medicare or Medicaid.

Section 115. Thirty-day coverage for services furnished by a home health agency whose agreement has been terminated

Section 115(a) amends Section 1866(b)(4)(B) of the Social Security Act to specify that if Medicare participation of a home health agency is terminated, the Secretary is required to continue to pay for services, provided pursuant to an individual plan of care, for only 30 days after the termination.

Section 115(b) specifies that the provision applies with respect to terminations whose effective date falls after 60 days after the date of the enactment.

Section 116. Health maintenance organization and competitive medical plans

Section 116(a) amends Section 1876(c)(3)(A) of the Social Security Act by requiring the Secretary, for each area served by more than one eligible health maintenance organization or competitive medical plan, to establish (after consultation with such entities) a single 30-day period each year during which all eligible organizations serving the area must provide for open enrollment under this section. The Secretary is required to determine the annual per capita rates in a manner that assures that individuals enrolling during such a 30-day period will not have premium charges increased or any additional benefits decreased during the 12-month enrollment period for which the individual is enrolling. The section further specifies that an entity may provide for such other open enrollment period or periods as it deems appropriate.

Section 116(b) amends Section 1876(g)(2) of the Social Security Act to specify that an entity (with the approval of the Secretary) may provide that a part of the value of additional benefits provided under a risks sharing contract be withheld and reserved by the Secretary for subsequent annual contract periods to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the entity.

Section 116(c)(1) makes technical correction to Section 1876(g)(4)(A) of the Act.

(2) makes technical corrections to Section 1876(h)(2) of the Act.

Section 1876(d) specifies that the Secretary of Health and Human Services may phase in, over a period of not longer than three years, the application of the amendments made by subsection (a) to all applicable areas in the United States if the Secretary determines that it is not administratively feasible to establish a single 30-day open enrollment period for all such applicable areas before the end of the period.

Section 117. Flexible sanctions for noncompliance with requirements for end-stage renal disease facilities

Section 117 amends Section 1881(c)(3) of the Social Security Act by specifying that where the Secretary determines that an ESRD facility's or provider's failure to cooperate with the Secretary's plans and goals does not jeopardize patient health or safety or justify termination of certification, he may, instead of terminating or

withholding certification (and after reasonable notice to the provider or facility and to the public) impose such other sanctions as may be appropriate. Such sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of the notice and graduated reduction in reimbusement for all patients.

Section 118. Repeal of requirement for end-stage renal disease networks

Section 118(a) amends Section 1881(c) of the Social Security Act by eliminating the requirement for end-stage renal disease networks and makes conforming changes. The new Section 1881(c) provides that for the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary may establish a national end-stage renal disease medical information system.

Section 118(b) amends Section 1881(g) of the Act to make conforming changes.

Section 118(c) provides that the amendments made by Section 118 shall take effect on a date, established and published by the Secretary and not earlier than January 1, 1984, as of which date the Secretary has in operation an alternative means of performing the essential data collection activities performed on the date of the enactment of this Act by renal disease networks.

Title II—Medicaid Reconciliation Amendments

Part A. Child Health Assurance Program Amendments

Section 201. Increased Federal medical assistance percentage for services provided to certain pregnant women and young children

Section 201(a)(1) amends Section 1905(b) of the Social Security Act to specify that the Federal Medical Assistance Percentage shall be 100 per centum with respect to amounts expended as medical assistance for services furnished with respect to a qualified pregnant woman or child (as defined in new Section 1905(n)).

(2)(A) amends Section 1903(s)(1)(A) to provide that the reductions in Federal matching payments are to be made without regard to expenditures for services furnished with respect to qualified pregnant women and children (as defined in new Section 1905(n)).

(B) amends Section 1903(s)(2) by adding a new subparagraph (D). The new subparagraph (D) specifies that the reduction otherwise applicable is to be reduced by one-half percentage point if the State provides (and provided as of June 30, 1983) for categorically needy coverage under Medicaid, as defined under clauses (i) and (ii)(I) of Section 1902(a)(10)(A), of pregnant women and children under the age specified in new Section 1905(n).

(3) amends Section 1903(t)(1)(A) of the Act to exclude payments for services with respect to qualified pregnant women and children as defined in section 1905)(n) in the calculation of the Medicaid target rate.

201(b) adds a new Section 1905(n) to the Social Security Act.

New Section 1905(n) defines the term "qualified pregnant woman or child" as a person who was not eligible for categorically needy coverage under Medicaid as the plan was in effect on June 30, 1983 and who is:

(1) A child born on or after January 1, 1983, who is under 5 years of age and who is described in Section 1902(a)(10)(A)(ii)(I) (which refers to a person who meets the AFDC requirements but is not receiving a cash payment) and covered under the State Medicaid plan as a categorically needy individual described in Section 1902(a)(10)(A), or

(2) a pregnant woman—

(A) whom the State has the option of deeming to be a recipient of aid to families with dependent children for purposes of Medicaid by reason of section 406(g)(2), or

(B) who is a member of a family which would be eligible for aid under section 407 if the State plan under part A of Title IV required the payment of aid with respect to dependent children deprived of parental support or care by reason of the unemployment of a parent who is the principal earner (as described in such section).

201(c)(1) specifies that except as provided in paragraph (2), the amendments made by Sections 201 (a) and (b) shall take effect on January 1, 1984, and apply to payments made to providers under State plans on and after that date.

(2) specifies that the amendment made by Section 201(a)(2)(B) shall apply to payments to States for quarters beginning on or after October 1, 1983.

(3) specifies that notwithstanding any provision of Title XIX of the Social Security Act, a State plan approved under such Title which did not make children described in section 1902(a)(10)(A)(ii)(I) of such Act eligible for coverage under the plan as of June 30, 1983, may limit the eligibility of coverage of such children to those who are qualified children described in Section 1905(n)(1) of such title.

201(d) specifies that effective for amounts expended for services furnished on or after October 1, 1986, paragraph (2) of section 1905(n) of the Social Security Act is amended to define a pregnant woman as one who is described in section 1902(a)(10)(A).

Section 202. Prohibiting "deeming" of income and resources with respect to certain minor pregnant women

Section 202(a) amends Section 1902(a)(17) by adding a new clause (E). This clause provides that required reasonable eligibility standards may, at the option of the State, not take into account the financial responsibility of any individual for an applicant or recipient who is a pregnant woman under age 21 and who does not have legal custody over other children, unless the applicant or recipient is the individual's spouse. A State may limit the application of this clause (E) to applicants and recipients who live in such an individual's household, in a custodial institution for pregnant women, or in either such a household or such an institution.

202(b)(1) provides that the amendment made by Section 202(a) applies (except as provided under paragraph (2)) to payments under Title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1984.

(2) provides that in the case of a State plan for medical assistance which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

Section 203. Clarification of medicaid entitlement for certain pregnant women

Section 203(a) amends Section 1902(e) of the Social Security Act by adding a new paragraph (4). New paragraph (4) clairfies that a child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains eligible for such assistance.

203(b) specifies that the amendment made by Section 203(a) applies to children born on or after October 1, 1983.

PART B. MISCELLANEOUS MEDICAID CHANGES

Section 211. Medically needy income levels

Section 211 amends Section 1903(f)(3) of the Social Security Act with respect to maximum medically needy income limitations. New paragraph (B) of this section provides that in the case of a family consisting only of two adults at least one of whom is aged, blind, or disabled, the term "highest amount which would ordinarily be paid to such family under the State's plan approved under part A of title IV of this Act shall, at the State's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources."

211(b) provides that the new paragraph shall apply to payments to States under section 1903 of the Social Security Act for calendar quarters beginning on or after January 1, 1984.

Section 212. Recertification of need for stays in skilled nursing and intermediate care facilities

Section 212(a)(1) amends Section 1903(g)(1) of the Social Security Act to provide that there is to be a reduction in Federal matching payments with respect to services furnished in a skilled nursing facility (SNF) after 30 days unless the State makes a satisfactory showing that it has a utilization control program.

(2) and (3) make conforming changes in Section 1903(g).

(4) adds a new subparagraph (C) to Section 1903(g)(4). Subparagraph (C) specifies that the Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph if the fraction referred to in

paragraph (5) with respect to that quarter is equal or less than 3 one-hundredths.

(5) amends paragraph 5 of Section 1903(g) to specify that the reduction for an invalid showing is 5 per centum multiplied by a fraction—

(A) The denominator of which is equal to the total number of patients, receiving the specified type of services in that quarter under the State plan, whose records were included in sample onsite surveys conducted with respect to that quarter and;

(B) The numerator of which is equal to the number of such patients receiving such specified type of services in that quarter whose records were found under such surveys not to comply with the requirements of subsection 1903(g).

(6) is amended by adding a new paragraph 7 under Section 1903(g) which specifies the following recertification requirements:

(1) for skilled nursing facility patients the required recertification is on or before 30, 60, and 90 days after the date of admittance to the facility; and each 60 days thereafter,

(2) for intermediate care facility inpatients the required frequency of recertification is: on or before 60 and 180 days after the date of admittance to the facility; on or before 12, 18, and 24 months after the date of admittance to the facility; and annually thereafter.

New paragraph (7) further provides that a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State can demonstrate that there was good cause for the physician's failure to meet the recertification deadline.

212(b) adds a new paragraph (8) to Section 1903(g).

New paragraph (8) provides that it is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under Medicaid, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.

212(c) provides that the amendments made by subsection (a) shall apply to calendar quarters beginning on or after January 1, 1984, except that the amendments made by paragraphs (1), (2), and (3), of subsection (a) and section 1903(g)(7)(A) of the Social Security Act (added by the amendment made by paragraph (6) of subsection (a)) shall not apply to individuals admitted to skilled nursing facilities before January 1, 1984.

Section 213. Waiver of certain membership requirements for certain health maintenance organizations

Section 213 amends Section 1903(m)(2) of the Social Security Act to provide that the Secretary may under certain circumstances modify or waive specified HMO membership requirements (which limit combined Medicare/Medicaid membership to 75 percent of the total) with respect to an entity's meeting the following conditions:

(1) it is a nonprofit organization with at least 25,000 members,

(2) it is and has been a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) for a period of at least four years,

(3) it provides basic health services through members of the staff of the organization,

(4) it is located in an area designated as medically underserved under section 1302(7) of the Public Health Service Act, and;

(5) it previously received a waiver of the membership requirement in Section 1903(m)(2)(A)(ii) under Section 1115.

Section 213 further provides that the Secretary may modify or waive the membership requirement only if he determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under Medicare or Medicaid.

Section 214. Prohibiting medicaid copayments for prescribed drugs

Section 214(a) amends Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Act to prohibit the imposition of copayments on prescribed drugs.

214(b) specifies that the amendment applies to payments under Medicaid for calendar quarters beginning on or after January 1, 1984. Where the Secretary determines that the State Medicaid plan requires State legislation to meet the requirement, the State plan shall not be regarded as failing to comply with Medicaid requirements solely on the basis of its failure to meet these additional requirements before July 1, 1984.

Section 215. Maximum amount of medicaid payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa

Section 215 amends Section 1108(c)(1)–(5) of the Social Security Act to increase, effective with fiscal year 1984, the maximum Federal matching payments to the territories as follows: Puerto Rico, $77,100,000; the Virgin Islands, $2,600,000; Guam, $2,400,000; the Northern Mariana Islands, $600,000; and American Samoa, $1,300,000.

Section 216. Payment for psychiatric hosptial services

Section 216 provides that the provisions of Section 1902(a)(13) in so far as they require a reduction of the amount of payment otherwise to be made to a public psychiatric hospital due to the level of care received in such hospital, shall not apply to payments to hospitals before July 1, 1985. Such a reduction made for payments during the 12-month period ending June 30, 1986, and during the 12-month period ending June 30, 1987 shall be one-third and two-thirds, respectively, of the amount of the reduction which would otherwise be required under section 1902(a)(13).

Title III—Recovery of Hill Burton Funds

Section 301(a) amends section 609 of the Public Health Service Act as follows:

New Section 609(a) provides that if any facility which received funds for construction and modernization under Section 606 of the Act, at any time within 20 years after the completion of construction or modernization, (1) is sold or transferred to an entity not qualified to file an application under Section 605 or is not approved as a transferee by the designated State agency or its successor, or (2) ceases to be as public health center or a public or other nonprofit hospital, outpatient facility, long-term care facility, or rehabilitation facility, then the United States is entitled to recover from the transferor or the transferee (or from the owners of a facility which has ceased to be public or nonprofit) an amount determined under new subsection (c).

609(b) requires the transferor of a facility which is sold or transferred or the owner of a facility which has ceased to be public or nonprofit to provide the Secretary with written notice of the sale, transfer, or change not later than the expiration of 10 days from the date of the sale, transfer, or change.

609(c)(1) requires that, except as provided in new paragraph (2), the amount the United States is entitled to recover under new subsection (a) is an amount bearing the same ratio to the then value (as determined by the agreement of the parties or in an action brought in the U.S. District Court where the facility is situated) of so much of the facility as constituted an approved project as the amount of the Federal participation bore to the cost of the construction or modernization of such project.

(2)(A) entitles the United States, after the expiration of:

(i) 180 days after the date of sale, transfer, or change of use which occurs after the date of enactment; or

(ii) July 1, 1984, for facilities which were sold or transferred or the use changed before the date of enactment,

to recover an amount equal to the amount described in new paragraph (1) plus interest, at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate.

(B) provides that the period of time during which the United States is entitled to recover amounts is the period beginning:

(i) July 1, 1984, for facilities sold or transferred or whose use changed before the date of enactment;

(ii) after 180 days after the receipt of notice to the Secretary described in new subsection (b), for facilities with respect to which such notice is provided; or

(iii) on the date of the sale, transfer, or change of use, in the case of a facility with respect to which such notice was not provided as prescribed by new subsection (b), and ending on the date the amount the United States is entitled to is collected.

609(d) authorizes the Secretary to waive the recovery rights of the United States under new subsection (a)(2) with respect to a facility in any State if the Secretary determines, in accordance with regulations, that there is good cause for doing so.

609(e) provides that the right of recovery of the United States under subsection (a) constitutes a lien on any facility with respect to which funds have been paid under Section 606.

Section 301(b) amends Section 1622 of the Public Health Service Act as follows:

New Section 1622(a) provides that if any facility which received funds under Title XVI of the Act, at any time within 20 years after the completion of construction or modernization, (1) is sold or transferred to an entity not qualified to file an application under Section 1621 or Section 1642 or is not approved as a transferee by the State Agency of the State in which the facility is located, or its successor, (2) ceases to be a public health center or a public or other nonprofit hospital, outpatient facility, long-term care facility, or rehabilitation facility, then the United States is entitled to recover from the transferor or the transferee (or from the owners of a facility which has ceased to be public or nonprofit) an amount determined under new Subsection (c).

1622(b) requires the transferor of a facility which is sold or transferred or the owner of a facility which has ceased to be public or nonprofit to provide the Secretary with written notice of the sale, transfer, or change not later than the expiration of 10 days from the date of the sale, transfer, or change.

1622(c)(1) requires that, except as provided in new paragarph (2), the amount the United States is entitled to recover under new subsection (a) is an amount bearing the same ratio to the then value (as determined by the agreement of the parties or in an action brought in the U.S. District Court where the facility is situated) of so much of the facility as constituted an approved project as the amount of the Federal participation bore to the cost of the construction or modernization of such project.

1622(c)(2)(A) entitles the United States, after the expiration of:

(i) 180 days after the date of sale, transfer or change of use which occurs after the date of enactment or

(ii) July 1, 1984, for facilities which were sold or transferred or the use changed before the date of enactment,

to recover an amount equal to the amount described in new paragraph (1) plus interest, at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate.

1622(c)(2)(B) provides that the period of time during which the United States is entitled to recover amounts is the period beginning:

(i) July 1 1984, for facilities sold or transferred or whose use changed before the date of enactment;

(ii) after 180 days after the receipt of notice to the Secretary described in new subsection (b), for facilities with respect to which such notice is provided; or

(iii) on the date of the sale, transfer, or change of use, in the case of a facility with respect to which such notice was not provided as prescribed by new subsection (b), and ending on the date the amount the United States is entitled to is collected.

1622(d) authorizes the Secretary to waive the recovery rights of the United States under new subsection (a)(2) with respect to a fa-

cility in any State if the Secretary determines, in accordance with regulations, that there is good cause for doing so.

1622(e) provides that the right of recovery of the United States under subsection (a) constitutes a lien on any facility with respect to which funds have been paid under this title.

Section 301(c) requires the Secretary, not later than the expiration of the 180th day beginning on the date of enactment of this section, to have in effect regulations and personnel to place in effect the amendments made by this section.

Title IV—Technical Amendments Relating to Title V or Title XIX of the Social Security Act

Section 401. Miscellaneous technical amendments

The Committee bill makes various technical amendments to Titles XIX and V of the Social Security Act. No change in policy whatsoever is intended.

It has come to the Committee's attention that some uncertainty remains in some quarters as to whether or not health care facilities and other providers that participate in the Medicare and Medicaid programs are recipients of Federal financial assistance. In view of the Committee, it has always been clear that Medicare and Medicaid funds constitute Federal financial assistance. The Committee wishes to reaffirm that health care facilities and other providers that receive Medicare and Medicaid funds are required, under existing statutes and long-standing Department of Health and Human Services regulations and interpretations, to provide services without discrimination not just to Medicare and Medicaid beneficiaries, but to all patients.

Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

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TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

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PAYMENTS TO STATES

Sec. 503. (a) From the sums appropriated therefor and the allotments available under section 502(b), the Secretary shall make payments as provided by [section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213)] *section 6503(a) of title 31, United States Code* to each State provided such an allotment under section 502(b), for each quarter, of an amount equal to four-sev-

enths of the total of the sums expended by the State during such quarter in carrying out the provisions of this title.

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REPORTS AND AUDITS

SEC. 506. (a)(1) * * *

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(d)(1) For the purpose of evaluating and reviewing the block grant established under this title, the Secretary and the Comptroller General shall have access to any books, accounts, records, correspondence, or other documents that are related to such block grant, and that are in the possession, custody, or control of States, political subdivisions thereof, or any of their grantees.

(2) In conjunction with an evaluation or review under paragraph (1), no State or political subdivision thereof (or grantee of either) shall be required to create or prepare new records to comply with paragraph (1).

(3) For other provisions relating to deposit accounting, reports, and auditing with respect to Federal grants to States, see [section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212)], *section 6503(b) of title 31, United States Code.*

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

PART A—GENERAL PROVISIONS

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LIMITATION ON PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

SEC. 1108. * * *

(a) * * *

* * * * * * *

(c) The total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

[(1) Puerto Rico shall not exceed $45,000,000,

[(2) the Virgin Islands shall not exceed $1,500,000,

[(3) Guam shall not exceed $1,400,000,

[(4) the Northern Mariana Islands shall not exceed $350,000, and

[(5) American Samoa shall not exceed $750,000.]

(1) Puerto Rico shall not exceed $77,100,000,

(2) the Virgin Islands shall not exceed $2,600,000,

(3) Guam shall not exceed $2,400,000,

(4) the Northern Mariana Islands shall not exceed $600,000, and

(5) American Samoa shall not exceed $1,300,000.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may be regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriated to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

[(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;]

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing

care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 186(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7) and needs or needed skilled nursing care on an intermittent basis of physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services [and inpatient tuberculosis hospital services]) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

[(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indi-

cate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;]

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility);

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

(8) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)), of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), and

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual's attending physician and by the medical director (and the disciplinary group described in section 1861(dd)(2)(B)) of the hospice program; and

(C) such care is being or was provided pursuant to such plan of care.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), [(B),] (C), (D), or (E) of paragraph

(2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractural relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.

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Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

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payment of benefits

Sec. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the Insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, [(D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (h) of this section),] *(D) with respect to diagnostic laboratory tests for which payment is made under this part, the amounts paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii) or under the*

procedure described in section 1870(f)(1)) of the lesser of (i) the amount determined under subsection (h), or (ii) the amount of the charges billed for the tests, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for physicians' services (furnished by a physician who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all physicians' services which are preadmission diagnostic services furnished by the physician to individuals enrolled under this part) which are preadmission diagnostic services for which payment may be made under this part and which are furnished (i) in the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital, or (ii) to the extent practicable as determined by regulations prescribed by the Secretary, in a physician's office within seven days of such individual's admission to a hospital as an inpatient, the amounts paid shall be equal to the reasonable charges for such services,[65] (G) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services,[66] and (H) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services,[67] and

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), and (F) of such section and in paragraph (5) of this subsection and unless otherwise specified in section 1881)—

(A) with respect to home health services and to items and services described in section 1861(s)(10), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(B) with respect to other services (except those described in subparagraph (C) *or (D)* of this paragraph and except as may be provided in section 1886)—

(i) the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may

the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section; [and]

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services; *and*

(D) with respect to diagnostic laboratory tests for which payment is made under this part, 100 percent of the lesser of (i) the amount determined under subsection (h), or (ii) the amount of the charges billed for the tests;

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 except that (1) such total amount shall not include expenses incurred (A) for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part, or (B) for items and services described in section 1861(s)(10), (2) such deductible shall not apply with respect to home health services, [and] (3) such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4), *and (4) such deductible shall not apply with respect to diagnostic laboratory tests for which payment is made under this part on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider of services with an agreement in effect under section 1866.* The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person fur-

nishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

* * * * * * *

[(h) With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to established a payment rate which is acceptable to the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate.]

(h)(1) The Secretary shall establish in accordance with this subsection a national fee schedule for diagnostic laboratory tests for which payment is made under this part.

(2) Except as provided in paragraph (4), the Secretary shall set the fee schedule at 60 percent of the prevailing charges paid under this part for similar diagnostic laboratory tests during the fee screen year beginning July 1, 1983, adjusted annually to reflect changes in the Consumer Price Index for All Urban Consumers (U.S. city average) and subject to such other adjustments as the Secretary determines are justified by technological changes.

(3) In addition to the amounts provided under the fee schedule, the Secretary shall provide for and establish a nominal fee to cover the costs in collecting the sample on a diagnostic laboratory test that was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter.

(4)(A) During the 3-year period beginning March 1, 1984, the Secretary may provide for the fee schedule under this subsection to be established on a regional or statewide basis if the Secretary determines that a national fee schedule is inappropriate at such time because of limitations in the data available to establish such a schedule.

(B) In establishing a fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(5) In the case of a bill or request for payment for a diagnostic laboratory test for which payment may otherwise be made under this part—

(A) no payment may be made under this part to a physician with respect to such test unless the physician (or another physician with whom the physician shares his practice) personally performed or supervised the performance of the test, and

(B) payment for such a test performed by a laboratory which is independent of a physician's office or a rural health clinic may only be made on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section

1970(f)(1), or to a provider of services with an agreement in effect under section 1866.

* * * * * * *

(k) With respect to services described in section 1861(s)(10)(B), the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

* * * * * * *

(b)(1) * * *

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(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A)*(i)* to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or [(B)] *(ii)* (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, *or (B) to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part.* No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) [or (B)] of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or

other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

(6)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

(i) unless—

(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this title, and

(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this title and who were furnished services described in subclause (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

(ii) to the extent that the amount of the payment exceeds the reasonable charge for the services (with the customary charge determined consistent with subparagraph (B)).

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a [physician who has a substantial practice outside the teaching setting] *physician who is not teaching physician (as defined by the Secretary),* the carrier shall take into account the amounts the physician charges for similar services in the physician's [outside practice] *practice outside the teaching setting.*

(ii) [In the case of a physician who does not have a practice described in clause (i)] *Except as provided under clause (iii), in the case of a teaching physician,* if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the [greater] *greatest* of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i), [or]

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients[.] , *or*

(III) 75 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in the hospitals agree to have payment made for all physicians' services under this part

furnished patients in the hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1870(f)(1), the carrier shall take into account the amounts otherwise payable under this part with respect to similar services in the same locality.

* * * * * * *

[(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

[(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under title XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any individual who would (but for this subsection) be excluded from the agreement, subsections (c) and (d)(2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection(d)(2)(C) shall be applied by substituting "second month following the first month" for "first month".]

(i)(1) The Secretary shall compile annually a list of physicians serving individuals enrolled under this part indicating the share (by percentile intervals not to exceed quartiles) of claims which each physician has accepted on an assignment basis (described in subsection (b)(3)(B)(ii)) or has had payment made under the procedure described in section 1870(f)(1) in the preceding year.

(2) The Secretary shall make available in each office of the Social Security Administration the information compiled under paragraph (1) for the local geographic area served by the office no more than six months after the end of each year and, upon request, by mail from each carrier. The Secretary shall, when such information becomes available, annually notify each individual enrolled under this part of the availability of such information.

(j)(1) The Secretary shall publish annually a list of all physicians who have agreed in accordance with this subsection to accept payment under this part on the basis of an assignment (described in subsection (b)(3)(B)(ii)) or under the procedure described in section 1870(f)(1) for all services furnished under this part during the following twelve-month period to individuals enrolled under this part.

(2) To permit the publishing of the list provided under paragraph (1), the Secretary shall annually, before the beginning of the twelve-month period, offer physicians a reasonable opportunity to sign an agreement that they will accept payment under this part on the basis of an assignment (described in subsection (b)(3)(B)(ii)) or under the procedure described in section 1870(f)(1) for all services furnished under this part during the following twelve-month period to individuals enrolled under this part.

(3) The Secretary shall annually provide to each individual enrolled under this part and residing in a local geographic area notice

of the availability of the list of all physicians in that area who have signed such an agreement for the following twelve-month period.

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PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

[Inpatient Tuberculosis Hospital Services

[(d) The term "inpatient tuberculosis hospital services" means inpatient hospital services furnished to an inpatient of a tuberculosis hospital.]

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d). 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979[130], the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of section 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases [or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or] unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as

may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may,[131A] waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; *and*

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution [; and].

[(5) is accredited by the Joint Commission on Accreditation of Hospitals.]

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital" [if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary].

[Tuberculosis Hospital

[(g) The term "tuberculosis hospital" means an institution which—

[(1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;

[(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

[(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;

[(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

[(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of

Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.]

* * * * * * *

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

(10) has in effect an overall plan and budget that meets the requirements of subsection (z);

(11) complies with the requirements of section 1124;

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

(13) meets such provisions of such edition (as is specified by the Secretary in regulations) of [136] [137] the Life Safety Code of the National Fire Protection Association [138] as are applicable

to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and [139]

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863), except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution. Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under titles XVIII and XIX of this Act;

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases [or tuberculosis]. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing

services on days when the regular full-time registered professional nurse is not on duty.

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) * * *

* * * * * * *

(10)(*A*) pneumococcal vaccine and its administration[.]*; and*

(B) hepatitis B vaccine and its administration, furnished in a hospital or a renal dialysis facility.

* * * * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

(b)(1) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made *promptly* (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been *or may be* made under such a law or plan, policy, plan, or insurance. *The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a law, policy, plan, or insurance (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment), by bringing an action against the entity to which payment has been so made (if the entity is other than the individual entitled to benefits under this title), or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a law, policy, plan, or insurance.* The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

(2)(A) In the case of an individual who is entitled to benefits under part A or is eligible to enroll under part B solely by reason of section 226A, payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service furnished during the period described in subparagraph (C) to the extent that payment with respect to expenses for such item or service (i) has been made under any group health plan (as defined in 162(i)(2) of the Internal Revenue Code of 1954) or (ii) the Secre-

tary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this title.

(B) Any payment under this title with respect to any item or service furnished to an individual described in subparagraph (A) during the period described in subparagraph (C) shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been *or may be* made under a plan described in subparagraph (A). *The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a plan (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment), by bringing an action against the entity to which payment has been so made (if th entity is other than the individual entitled to benefits under this title), or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a plan.* The Secretary may waive the provisions of this subparagraph in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant pursuing of the claim.

(3)(A)(i) Payment under this title may not be made, except as provided in clause (ii), with respect to any item or service furnished in any month during the period described in clause (iii) to an individual who is over 64 but under 70 years of age during any part of such month (or to the spouse of such individual, if the spouse is over 64 but under 70 years of age) who is employed at the time such item or service in furnished to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made, under a group health plan (as defined in clause (iv)) under which such individual is covered by reason of such employment.

(ii) Any payment under this title with respect to any item or service during the period described in clause (iii) shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been *or may be* made under a group health plan. *The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a plan (if the entity would be required to make payment if an appropriate claim were pursued, but only to the entent that the entity has not already made payment), by bringing an action against the entity to which payment has been so made (if the entity is other than the individual entitled to benefits under this title), or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a plan.* The Secretary may waive the provisions of this clause in the case of an individual claim if he determines that

the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), [(g)(4),] (j)(11), (o)(6), (cc)(2)(I), and (dds)(2) of section 1861, or by ambulatory surgical centers under section 1832(a)(2)(F)(i), the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4) section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per cemtum, of the reasonable charges for such items and services (not in excess of 20 per cemtum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case fo items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substitution for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10) *and with respect to diagnostic laboratory tests* for which payment is made under part B.

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated—

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice by the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed (i) to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request and specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary to be substantially in excess of the need of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1126(a), *or that any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a).*

Any termination shall be applicable—

(3) in the case of inpatient hospital services (including [tuberculosis hospital services and] inpatient psychiatric hospital services) or post-hospital extended care services, with respect

to services furnished after the effective day of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.

(4)(A) with respect to home health services or hospice care furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective day, with respect to such services furnished to such individual after [the calendar year in which] *30 days after* such termination is effective, and

(5) with respect to any other items and services furnished on or after the effective day of such termination.

* * * * * * *

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including [inpatient tuberculosis services and] inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

* * * * * * *

(g)(1) The Secretary shall, through the Commissioner of the Food and Drug Administration, provide for a registry of all cardiac pacemaker devices and pacemaker leads for which payment was made under this title. Such registry shall include the manufacturer, model, serial number, and manufacturer's price of each such device or lead, the name of the recipient of such device or lead, the date and location of the implantation or removal of the device or lead, the name of the physician involved in implanting or removing such device or lead, the name of the hospital or other provider billing for such procedure, any express or implied warranties associated with such device or lead under contract or State law, and such other information as the Secretary deems to be appropriate. Such registry shall be for the purposes of assisting the Secretary in determining when payments may properly be made under this title, determining when inspection by the Food and Drug Administration may be necessary under paragraph (2), and carrying out studies with respect to

the use of such devices and leads. In carrying out any such study, the Secretary may not reveal any specific information which identifies any pacemaker device or lead recipient by name (or which would otherwise identify a specific recipient). Any person or organization may provide information to the registry with respect to cardiac pacemaker devices and leads other than those for which payment is made under this title.

(2) In any case where the Secretary has reason to believe, based upon information in the pacemaker registry or otherwise available to him, that replacement of a cardiac pacemaker device or lead for which payment is or may be requested under this title is related to the malfunction of a device or lead, the Secretary may require that personnel of the Food and Drug Administration test such device, or be present at the testing of such device by the manufacturer, to determine whether such device was functioning properly.

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PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) * * *

* * * * * * *

(c)(1) The Secretary may not enter into a contract under this section with an eligible organization unless it meets the requirements of this subsection and subsection (e) with respect to members enrolled under this section.

(2) The organization must provide to members enrolled under this section, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

(A) only those services covered under parts A and B of this title, for those members entitled to benefits under part A and enrolled under part B, or

(B) only those services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization, except that (i) the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered, and (ii) in the case of an organization with a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(3)(A)(*i*) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days duration every year *and including the 30-day period specified under clause (ii),* and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d)

in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(ii) For each area served by more than one eligible organization under this section, the Secretary (after consultation with such organizations) shall establish a single 30-day period each year during which all eligible organizations serving the area must provide for open enrollment under this section. The Secretary shall determine annual per capita rates under subsection (a)(1)(A) in a manner that assures that individuals enrolling during such a 30-day period will not have premium charges increased or any additional benefits decreased during the 12-month enrollment period for which the individual is enrolling. An eligible organization may provide for such other open enrollment period or periods as it deems appropriate consistent with this section.

* * * * * * *

(g)(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b) which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

(2) Each risk-sharing contract shall provide that—

(A) if the adjusted community rate, as defined in subsection (e)(3), for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so re-

duced) *and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary for subsequent annual contract periods to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3).* If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entererd into under this section.

(3) The additional benefits referred to in paragraph (2) are—

(A) The reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this section, or

(B) the provision of additional health benefits,

or both.

(4) A risk-sharing contract under this subsection may, at the option of an eligible organization, provide that the Secretary—

(A) will reimburse hospitals and other providers of services either for payment amounts determined in accordance with section 1886, or, if applicable, for the reasonable cost (as determined under section 1861(v)) *or other appropriate basis for payment established under this title,* of [inpatient hospital] services furnished to individuals enrolled with such organization pursuant to subsection (d), and

(B) will deduct the amount of such reimbursement for payment which would otherwise be made to such organization.

(h)(1) * * *

(2) A reasonable cost reimbursement contract under this subsection may, at the option of such organization, provide that the Secretary—

(A) will reimburse hospitals and [skilled nursing facilities] *other providers of services* either for the reasonable cost (as determined under section 1861(v)) [or], for payment amounts determined in accordance with section 1886 or other appropriate basis for payment established under this title, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (d), and

(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.

If such an eligible organization pays a hospital or [skilled nursing facility] *or other provider of services* directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) [or], the amount determined under section 1886 or other appropriate basis for payment established under this title, as applicable, unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

* * * * * * *

MEDICARE COVERAGE FOR END-STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

* * * * * * *

[(c)(1)(A) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall establish, in accordance with such criteria as he finds appropriate, renal disease network areas, such network organizations (including a coordinating council, an executive committee of such council, and a medical review board, for each network area) as he finds necessary to accomplish such purpose, and a national end-stage renal disease medical information system. The Secretary may by regulations provide for such coordination of network planning and quality assurance activities and such exchange of data and information among agencies with responsibilities for health planning and quality assurance activities under Federal law as is consistent with the economical and efficient administration of this section and with the responsibilities established for network organizations under this section.

[(B) At least one patient representative shall serve as a member of each coordinating council and executive committee.

[(C) The Secretary shall, in regulations, prescribe requirements with respect to membership in network organizations by individuals (and the relatives of such individuals) (i) who have an ownership or control interest in a facility or provider which furnishes services referred to in section 1861(s)(2)(F), or (ii) who have received remuneration from any such facility or provider in excess of such amounts as constitute reasonable compensation for services (including time and effort relative to the provision of professional medical services) or goods supplied to such facility or provider; and such requirements shall provide for the definition, disclosure, and, to the maximum extent consistent with effective administration, prevention of potential or actual financial or professional conflicts of interest with respect to decisions concerning the appropriateness, nature, or site of patient care.]

(c)(1) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary may establish a national end-stage renal disease medical information system.

[(6)] *(2)* It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated. The Secretary shall consult with appropriate professional [and network] organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation. The Secretary shall periodically submit to the Congress such legislative recommendations as the Secretary finds warranted on the basis of such consultation and evidence to further the national objective of maximizing the use of home dialysis and transplantation consistent with good medical practice.

[(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

[(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient;

[(B) developing criteria and standards relating to the quality and appropriateness of patient care; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation;

[(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities;

[(D) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction; and

[(E) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.]

(3) Where the Secretary determines, on the basis of [the data contained in the network's annual report and such other] *such* relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with [network plans] *the Secretary's plans* and goals, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the [network's plans] *those plans* and goals. *Where the Secretary also determines that the facility's or provider's failure to cooperate with the Secretary's plans and goals does not jeopardize patient health or safety or justify termination of certification, he may, instead of terminating or withholding certification and after reasonable notice to the provider or facility and to the public, impose such other sanctions as may be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of the notice and graduated reduction in reimbursement for all patients.*

[(4) The Secretary shall, in determining whether to certify additional facilities or expansion of existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report.

[(5) The Secretary, after consultation with appropriate professional and planning organizations, shall provide such guidelines

with respect to the planning and delivery of renal disease services as are necessary to assist network organizations in their development of their respective networks' goals to promote the optimum use of self-dialysis and transplantation by suitable candidates for such modalities.]

* * * * * * *

(g) The Secretary shall submit to the Congress on July 1, 1979, and July 1 of each year thereafter a report on the end stage renal disease program, including but not limited to—

(1) the number of patients, [nationally and by renal disease network,] on dialysis (self-dialysis or otherwise) at home and in facilities;

(2) the number of new patients entering dialysis at home and in facilities during the year;

(3) the number of facilities providing dialysis and the utilization rates of those facilities;

(4) the number of kidney transplants, by source of donor organ;

(5) the number of patients awaiting organs for transplant;

(6) the number of transplant failures;

(7) the range of costs of kidney acquisitions, by type of facility and by region;

(8) the number of facilities providing transplant and the number of transplants performed per facility;

(9) patient mortality and morbidity rates;

(10) the average annual cost of hospitalization for ancillary problems in dialysis and transplant patients, and drug costs for transplant patients;

(11) medicare payment rates for dialysis, transplant procedures, and physician services, along with any changes in such rates during the year and the reasons for those changes;

(12) the results of cost-saving experiments;

(13) the results of basic kidney disease research conducted by the Federal Government, private institutions, and foreign governments; *and*

[(14) information on the activities of medical review boards and other networks organizations; and]

[(15)](*14*) estimated program costs over the next five years.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

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(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the secre-

tary for the purpose specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public insitutions in which recipients of medical assistance under the plan may receive care in services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

[NOTE: THE BILL REALIGNS THE FOLLOWING SUBPARAGRAPH TO CONFORM TO THE INDENTATIONS OF THE PRECEDING SUBPARAGRAPHS]

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (11) and (12) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G),

[NOTE: THE BILL REALIGNS THE FOLLOWING SUBPARAGRAPH A TO CONFORM TO THE INDENTATIONS OF THE SUBSEQUENT SUBPARAGRAPHS]

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to—

(i) all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI; and

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care cost were paid from their earnings rather than by a State agency as a service expenditure.

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i)

if coverage under such plan was as broad as allowed under Federal law.

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI, or a State supplementary payment;

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income programs and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C), or

(VI) who would be eligible under the State plan under this title if they were a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1915(c) they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will received home or community-based services pursuant to a waiver granted by the Secretary under section 1915(c);

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A); and

* * * * * * *

(13) provide—

[(A) for payment of the hospital] *(A) for payment (except where the State agency is subject to an order under section 1914) of the hospital* skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1861(v)(1)(G)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1861(v)(1)(G)) which the State finds, and makes assurances satisfactory to the Secretary, are

reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility and intermediate care facility and periodic audits by the State of such reports; and

* * * * * * *

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, [and] (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program), and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law, *and (E) at the option of the State, do not take into account the financial responsibility of any individual for an applicant or recipient who is a pregnant woman under age 21 and who does not have legal cus-*

tody over other children, unless the applicant or recipient is the individual's spouse, except that a State may limit the application of this clause (E) to applicants and recipients who live in such an individual's household, in a custodial institution for pregnant women, or in either such a household or such an institution;

* * * * * * * *

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a [periodical] *periodic* determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii) [, section 603(a)(1)(A)(i) and (ii),] or section 1603(a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

* * * * * * *

(26 effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility; (B) for periodic inspections to be made in all skilled nursing facilities and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physi-

cians and other appropriate health and social service personnel, or, in the case or skilled nursing facilities, composed of physicians or registered nurses and other appropriate health and social service personnel of (i) the care being provided in such nursing facilities (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such [homes] *facilites* (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing facilites (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections together with any recommendations to the State agency administering or supervising the administration of the State plan;

* * * * * * *

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases [and tuberculosis] shall not apply for purposes of this title;

* * * * * * *

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the [penultimate] *second* sentence of this subsection; and

* * * * * * *

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such [part] *title*, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a); *and*

[(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supevise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h); and]

[(44)] *(43)* provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(a)(4)(B),

(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). [For purposes of paragraphs (9)(A), (26) (29), (31), and (33) and of section 1903(i)(4), the terms "skilled nursing facility "and" "nursing home" do not include] *The provisions of paragraphs (9)(A), (26), (31), and (33) and of section 1903(i)(4), shall not apply to* a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter is such individual would have been eligible for financial aid or assistance for such month had the increase in

monthly insurance benefits under title II resulting from enactment of Public Law 92–336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.

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(e)(1) * * *

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(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains eligible for such assistance.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to [clause] *paragraph* (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under [clause] *paragraph* (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under [clause] *paragraph* (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under [clause] *paragraph* (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to [clause] *paragraph* (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this

section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under [clause] *paragraph* (10)(A) of that subsection.

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PAYMENT TO STATES

SEC. 1903. (a) * * *

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(f)(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3)*(A)* For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(B) For purposes of paragraph (1)(B), in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the "highest amount which would ordinarily be paid to a family of the same size" under the State's plan approved under part A of title IV of this Act shall, at the State's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable

under such plan to a family which consists of one adult and two children and which is without any income or resources. In the case of a State which has an applicable income limitation under this subsection which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) for families other than those described in the previous sentence, section 1902(a)(10)(C)(i)(III) shall not prevent the State from establishing under the previous sentence an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families.

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(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital [(including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days] *or intermediate care facility on 60 days, in a skilled nursing facility on 30 days* or in a hospital for mental deseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services [(including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days] *or intermediate care facility furnished beyond 60 days or skilled nursing facility services furnished beyond 30 days* (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the state an effective program of control over utilization of such services; such a showing must include evidence that—

(A) in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician, or a physician assistant or nurse practitioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days (*or, in the case of services that are skilled nursing facility or intermediate care facility services other than in an institution for the mentally retarded, at least as frequently as provided under paragraph (7),* or, in the case of services that are intermediate care facility services provided in an institution for the mentally retarded, every year), and accompanied by such supporting material, appropri-

ate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

(B) in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(C) such State has in effect a continuous program of review of utilization pursuant to section 1902(a)(30) whereby each admission is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved; and the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 per centum of all admissions and must be of sufficient size to serve the purpose of (i) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (ii) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted; and

(D) such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to section 1902(a)(26) and (31) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams.

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under [paragraph] *paragraphs* (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 percent of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due [deligence] *diligence* in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have such a showing but for failings of a technical nature only.

(C) The Secretary shall find a showing of a State, with respect to a calendar quarter paragraph (1), to be satisfactory under such paragraph with respect to the requirements of subparagraphs (A) and (B) of such paragraph as applicable to a type of facility or institutional services, if the fraction referred to in paragraph (5)(B) with respect to that quarter for that type of services is equal to or less than 3 one-hundreths.

[(5) In] *(5)(A)(i) Except as provided in subparagraph (B), in* the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(ii) As used in clause (i), the term "showing" does not include a State's showing made with respect to the requirements of subparagraphs (A) and (B) of paragraph (1).

(B) In the case of a State's unsatisfactory and invalid showing made with respect to the requirements of subparagraph (A) and (B) of paragraph (1) wih respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1), in addition to the amount of any per centum reduction under subparagraph (A), is equal to 5 per centum multiplied by a fraction—

(A) the denominator of which is equal to the total number of patients, receiving that type of services in that quarter under the State plan, whose records were included in sample onsite surveys conducted with respect to such requirements for that quarter under paragraph (2), and

(B) the numerator of which is equal to the number of such patients receiving such type of services in that quarter whose records were found under such surveys not to comply with such requirements.

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(7)(A) With respect to inpatients of—

(i) skilled nursing facilities, the frequency of recertifications referred to in paragraph (1)(A) is—

(I) on or before 30, 60, and 90 days after the date of admittance to the facility, and

(II) each 60 days thereafter; and

(ii) intermediate care facilities, the frequency of recertifications referred to in paragraph (1)(A) is—

(I) on or before 60 and 180 days after the date of admittance to the facility,

(II) on or before 12, 18, and 24 months after the date of admittance to the facility, and

(III) annually thereafter.

(B) For purposes of this subsection, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State can demonstrate that there was good cause for the physician's failure to meet the recertification deadline.

(8) It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this title, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.

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(i) Payment under the preceding provisions of this section shall not be made—

(2) * * *

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(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner [.]; *or*

(7) with respect to any amount expended for diagnostic laboratory tests performed by a physician, indepednent laboratory, or hospital (other than for an inpatient of the hospital), to the extent such amount exceeds the amount payable under section 1833(h) for such tests.

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(m)(1)(A) * * *

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(2)(A) * * *

(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and [(II)] for the period beginning July 1, 1976, and ending on the expiration of the [*period*] for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not included inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

[THE BILL REALIGNS THE MARGINS OF THE FOLLOWING SUBPARAGRAPH TO CONFORM TO THE INDENTATIONS OF THE PRECEDING SUBPARAGRAPHS.]

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection [112] or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary) [113], whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

* * * * * * *

(E) In the case of a health maintenance organization that—

(i) is a nonprofit organization with at least 25,000 members,

(ii) is and has been a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) for a period of at least four years,

(iii) provides basic health services through members of the staff of the organization,

(iv) is located in an area designated as medically underserved under section 1302(7) of the Public Health Service Act, and

(v) previously received a waiver of the requirement described in subparagraph (a)(ii) under section 1115,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII.

* * * * * * *

(s)(1)(A) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State is otherwise entitled to receive under this title for any quarter in—

(i) fiscal year 1982, shall be reduced by 3 percent,

(ii) fiscal year 1983, shall be reduced by 4 percent, and

(iii) fiscal year 1984, shall be reduced by 4.5 percent,

of the amount to which the State is otherwise entitled (without regard to payments under subsections (a)(6) and (t), without regard to payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service *or furnished with respect to a qualifed pregnant woman a child (as defined in section 1905(n)),* and without regard to payments for claims relating to expenditures made before fiscal year 1982).

(B) no reduction may be made under subparagraph (A) for a quarter unless, as of the first day of the quarter, the Secretary has promulgated and has in effect final regulations (on an interim or other basis) implementing paragraphs (10)(C) and (13)(A) of section 1902(a) (as amended by the Medicare and Medicaid Amendments of 1981).

(C) for purposes of this paragraph, the term "State" only includes the fifty States and the District of Columbia and does not include any State which did not have a plan approved under this title a program in operation under as of July 1, 1981.

(2) The percentage reduction imposed by paragraph (1) for a State for a quarter shall be reduced—

(A) by one percentage point if the State has a qualified hospital cost review program (described in paragraph (3)) for the quarter.

(B) by one percentage point if the State has a high unemployment rate (as determined under paragraph (4)) for the quarter, [and]

(C) by one percentage point if the total amount of the State's third party and fraud and abuse recoveries (as defined in paragraph (5)(A)) for the previous quarter is equal to or exceeds one percent of the amount of federal payments that the Secretary estimates are due to the State under this title for that previous quarter (without regard to payments under subsection (t))[.], *and*

(D) by one-half percentage point if the State provides (and provided as of June 30, 1983) for coverage under the plan, under clauses (i) and (ii)(I) of section 1902(a)(10)(A), of—

(i) all children described in section 1905(a)(i) and in section 1902(a)(10)(A)(ii)(I);

(ii) all pregnant women whom the State has the option of deeming to be recipients of aid to families with dependent children for purposes of this title by reason of section 406(g)(2); and

(iii)(I) individuals receiving aid under a State plan under part A of title IV pursuant to section 407 by virtue of being deprived of parental support or care by reason of the unemployment of a parent who is the principal earner (as described in such section), or

(II) all pregnant women who are members of a family which would be eligible to receive aid under a State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid with respect to dependent children deprived of parental support or care by reason of the unemployment of a parent who is the principal earner (as described in such section).

* * * * * * *

(t)(1) The Secretary shall determine for each State (as defined in subsection (s)(1)(C)) for each of fiscal years 1982, 1983, and 1984, a target amount of Federal medicaid expenditures. Such target amount for a State for fiscal year—

(A) 1982, is equal to 109 percent of the estimate (based upon the last such estimate for such State received by the Secretry before April 1, 1981) of the Federal share of expenditures under this title (other than payments under subsection (d)(5), and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service *or furnished with respect to a qualified pregnant woman or child (as defined in section 1905(n))* without taking into account reductions in payment under subsection (s) or additional payments under this subsection, and without regard to payments for claims relating to expenditures made prior to October 1, 1980) in fiscal year 1981 for such State;

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom

supplemental security income benefits are not being paid under title XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI, or

(viii) pregnant women,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for [tuberculosis or] mental diseases);

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l) and any other ambulatory services which are offered by a rural health clinic (as defined in subsetion (l)) and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for [tuberculosis or] mental diseases) for individuals 21 years of age or older (B) effectivce July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for [tuberculosis or] mental diseases;

(15) intermediate care facility services (other than such services in an institution for [tuberculosis or] mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);

(17) services furnished by a nurse-midwife (as defined in subsection (m)) which [he] *the nurse-midwife* is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not [he] *the nurse-midwife* is under the supervision of, or associated with, a physician or other health care provider; and

(18) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such terms does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for [tuberculosis or] mental diseases.

For purposes of [clauses] *clause* (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American

Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of [subparagraph (B) of section 1101(a)(8).] *section 1101(a)(8)(B).* Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). *Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services furnished with respect to a qualified pregnant woman or child (as defined in subsection (n)).*

* * * * * * *

(d) The term "intermediate care facility services" may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and [which meet] *the institution meets* such standards as may be prescribed by the Secretary;

* * * * * * *

(h)(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

[(A) inpatient services which are provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;]

[(B) *(A)* inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

[(C) *(B)* inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

* * * * * * *

(m) The term "nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and

babies (throughout the maternity cycle) which [he] *the nurse* is legally authorized to perform in the State in which he performs such services.

(n) The term "qualified pregnant woman or child" means—

(1) a child born on or after January 1, 1983, who is under 5 years of age and who is described in section 1902(a)(10)(A)(ii)(I) and covered under the State plan as an individual described in section 1902(a)(10)(A), or

(2) a pregnant woman—

(A) whom the State has the option of deeming to be a recipient of aid to families with dependent children for purposes of this title by reason of section 406(g)(2), or

(B) who is a member of a family which would be eligible for aid under a State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid with respect to dependent children deprived of parental support or care by reason of the unemployment of a parent who is the principal earner (as described in such section); and

who is not eligible for coverage under the plan, as the plan was in effect on June 30, 1983, as an individual described in section 1902(a)(10)(A).

[NOTE: EFFECTIVE FOR AMOUNTS EXPENDED FOR SERVICES FURNISHED ON OR AFTER OCTOBER 1, 1986, PARAGRAPH (2) OF SECTION 1905(n) IS AMENDED TO READ AS FOLLOWS:]

(2) a pregnant woman who is described in section 1902(a)(10)(A)(ii)(I) and covered under the State plan as an individual described in section 1902(a)(10)(A); and

* * * * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) * * *

* * * * * * *

(c)(1) The Secretary may by waiver provide that a State plan approved under this [part] *title* may include as "medical assistance" under such plan payment for all or part of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

* * * * * * *

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

SEC. 1916. (a) The State plan shall provide that in the case of individuals described in section 1902(a)(10)(A) who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan;

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnacy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, or

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), [or] services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled, *or prescribed drugs;* and

* * * * * * *

(b) The State plan shall provide that in the case of individuals other than those described in section 1902(a)(10)(A) who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income.

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with repect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, and 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, intermediate care facility, or other medical institution, if such individu-

al is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal need, or

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), [or] (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled, *or prescribed drugs;* and

* * * * * * *

PUBLIC HEALTH SERVICE ACT

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TITLE VI—ASSISTANCE FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER MEDICAL FACILITIES

* * * * * * *

Part A—Grants and Loans for Construction and Modernization of Hospitals and Other Medical Facilities

* * * * * * *

[RECOVERY

Sec. 609. If any facility with respect to which funds have been paid under section 606 shall, at any time within twenty years after the completion of construction—

[(a) be sold or tranferred to any person, agency, organization (1) which is not qualified to file an application under section 605, or (2) which is not approved as a transferee by the State agency designated pursuant to section 604, or its successor, or

[(b) cease to be a public health center or a public or other nonprofit hospital, outpatient facility, facility for long-term care, or rehabilitation facility, unless the Surgeon General determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from this obligation,

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility which has ceased to be public or nonprofit, from the owners thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of the facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction or modernization under such project or projects. Such right of recovery shall not constitute a lien upon said facility prior to judgment.]

RECOVERY

SEC. 609. (a) If any facility with respect to which funds have been paid under section 606 shall, at any time within twenty years after the completion of construction or modernization—

(1) be sold or transferred to any entity (A) which is not qualified to file an application under section 605, or (B) which is not approved as a transferee by the State agency designated pursuant to section 604, or its successor, or

(2) cease to be a public health center or a public or other nonprofit hospital, outpatient facility, facility for long-term care, or rehabilitation facility,

the United States shall be entitled to recover, whether from the transferor or the transferee (or, in the case of a facility which has ceased to be public or nonprofit, from the owners thereof) an amount determined under subsection (c).

(b) The transferor of a facility which is sold or transferred as described in subsection (a)(1), or the owner of a facility the use of which is changed as described in subsection (a)(2), shall provide the Secretary written notice of such sale, transfer, or change not later than the expiration of 10 days from the date on which such sale, transfer, or change occurs.

(c)(1) Except as provided in paragraph (2), the amount the United States shall be entitled to recover under subsection (a) is an amount bearing the same ratio to the then value (as determined by the agreement of the parties or in an action brought in the district court of the United States for the district for which the facility involved is situated) of so much of the facility as constituted an approved project or projects as the amount of the Federal participation bore to the cost of the construction or modernization of such project or projects.

(2)(A) After the expiration of—

(i) 180 days after the date of the sale, transfer, or change of use for which a notice is required by subsection (b) in the case of a facility which is sold or transferred or the use of which changes after the date of the enactment of this subsection, or

(ii) July 1, 1984, in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection,

the amount which the United States is entitled to recover under paragraph (1) with respect to a facility shall be the amount prescribed by paragraph (1) plus interest, during the period described in subparagraph (B), at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate.

(B) The period referred to in subparagraph (A) is the period beginning—

(i) in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection, July 1, 1984,

(ii) in the case of a facility with respect to which notice is provided in accordance with subsection (b), upon the expiration of 180 days after the receipt of such notice, or

(iii) in the case of a facility with respect to which such notice is not provided as prescribed by subsection (b), on the date of the sale, transfer, or change of use for which such notice was to be provided,

and ending on the date the amount the United States is entitled to under paragraph (1) is collected.

(d) The Secretary may waive the recovery rights of the United States under subsection (a)(2) with respect to a facility in any State if the Secretary determines, in accordance with regulations, that there is good cause for waiving such rights with respect to such facility.

(e) The right of recovery of the United States under subsection (a) shall constitute a lien on any facility with respect to which funds have been paid under section 606.

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TITLE XVI—HEALTH RESOURCES DEVELOPMENT

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PART C—GENERAL PROVISIONS

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[RECOVERY

[SEC. 1622. (a) If any facility constructed, modernized, or converted with funds provided under this title is, at any time within twenty years after the completion of such construction, modernization, or conversion with such funds—

[(1) sold or transferred to any person or entity (A) which is no qualified to file an application under section 1621 or 1642, or (B) which is not approved as a transferee by the State Agency of the State in which such facility is located, or its successor; or

[(2) not used as a medical facility, and the Secretary has not determined that there is good cause for termination of such use,

the United States shall be entitled to recover from either the transferor or the trasferee in the case of a sale or transfer or from the owner in case of termination of use an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of such facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction, modernization, or conversion of such project or projects. Such right of recovery shall not constitute a lien upon such facility prior to judgment.

[(b) The Secretary may waive the recovery rights of the United States under subsection (a) with respect to a facility in any State—

[(1) if (as determined under regulations prescribed by the Secretary) the amount which could be recovered under subsection (a) with respect to such facility is applied to the development, expansion, or support of another medical facility located

in such State which has been approved by the Stateside Health Coordinating Council for such State as consistent with the State health plan established pursuant to section 1524(c); or

[(2) if the Secretary determines, in accordance with regulations, that there is good cause for waiving such requirements with respect to such facility.

If the amount which the United States is entitled to recover under subsection (a) exceeds 90 per centum of the total cost of the construction or modernization project for a facility, a waiver under this subsection shall only apply with respect to an amount which is not more than 90 per centum of such total cost.]

RECOVERY

SEC. 1622. (a) If any facility with respect to which funds have been paid under this title shall, at any time within twenty years after the completion of construction or modernization—

(1) be sold or transferred to any entity (A) which is not qualified to file an application under section 1621 or 1642 or (B) which is not approved as a transferee by the State Agency of the State in which such facility is located, or its successor, or

(2) cease to be a public health center or a public or other nonprofit hospital, outpatient facility, facility for long-term care, or rehabilitation facility,

the United States shall be entitled to recover, whether from the transferor or the transferee (or, in the case of a facility which has ceased to be public or nonprofit, from the owners thereof) an amount determined under subsection (c).

(b) The transferor of a facility which is sold or transferred as described in subsection (a)(1), or the owner of a facility the use of which is changed as described in subsection (a)(2), shall provide the Secretary written notice of such sale, transfer, or change not later than the expiration of 10 days from the date on which such sale, transfer, or change occurs.

(c)(1) Except as provided in paragraph (2), the amount the United States shall be entitled to recover under subsection (a) is an amount bearing the same ratio to the then value (as determined by the agreement of the parties or in an action brought in the district court of the United States for the district for which the facility involved is situated) of so much of the facility as constituted an approved project or projects as the amount of the Federal participation bore to the cost of the construction or modernization of such project or projects.

(2)(A) After the expiration of—

(i) 180 days after the date of the sale, transfer, or change of use for which a notice is required by subseciton (b) in the case of a facility which is sold or transferred or the use of which changes after the date of the enactment of this subsection, or

(ii) July 1, 1984, in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection,

the amount which the United States is entitled to recover under paragraph (1) with respect to a facility shall be the amount prescribed by paragraph (1) plus interest, during the period described in

subparagraph (B), at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rate.

(B) The period referred to in subparagraph (A) is the period beginning—

(i) in the case of a facility which was sold or transferred or the use of which changed before the date of the enactment of this subsection, July 1, 1984,

(ii) in the case of a facility with respect to which notice is provided in accordance with subsection (b), upon the expiration of 180 days after the receipt of such notice, or

(iii) in the case of a facility with respect to which such notice is not provided as prescribed by subsection (b), on the date of the sale, transfer, or change of use for which such notice was to be provided,

and ending on the date the amount the United States is entitled to under paragraph (1) is collected.

(d) The Secretary may waive the recovery rights of the United States under subsection (a)(2) with respect to a facility in any State if the Secretary determines, in accordance with regulations, that there is good cause for waiving such rights with respect to such facility.

(e) The right of recovery of the United States under subsection (a) shall constitute a lien on any facility with respect to which funds have been paid under this title.

* * * * * * *

SUPPLEMENTAL VIEWS OF THE HONORABLE THOMAS J. BLILEY, JR. (H.R. 4136)

Unlike many of my Republican colleagues, I supported H.R. 4136 and, in particular, the children's health initiative. I made my vote, in full knowledge of the impact on the treasury, because I believe the government has an obligation to protect unborn human beings.

Current Medicaid regulations result in the odd circumstance of a mother and child becoming eligible for Medicaid only after the child is born. From a medical standpoint, we know that the period before birth is as crucial to the child's healthy and productive development as its infancy. From a moral standpoint, those of us who consider ourselves pro-life know that the child is just as deserving of care and protection before birth as after. In either case, the need for medical assistance does not change simply by the event of birth.

I would urge all of my colleagues who are opposed to abortion to consider whether they have a positive obligation to protect and promote a baby's health beyond the action of simply forbidding abortion.

During full committee mark-up the Committee accepted an amendment I offered to further extend, at state option, Medicaid benefits to pregnant minors, regardless of their parent's income. My interest in this amendment was initiated in discussions with operators of homes for pregnant girls in connection with my duties on the Select Committee on Children, Youth and Families. In too many cases, teenaged girls are forced to leave their homes and live by themselves in order to qualify for health benefits made neces-

sary by their pregnancy. My amendment is designed to help teenaged girls in this physically and emotionally stressful state avoid a choice between leaving their families or forgoing adequate medical care.

Also during full committee mark-up the Committee accepted an amendment I offered eliminating End State Renal Disease Networks in the Medicare program. ESRD Networks are an outdated health regulatory bureaucracy which was established to pass judgment on applications for new kidney dialysis facilities. Despite an inordinate amount of money and time of medical professionals who could otherwise be treating patients, the ESRD networks serve almost no useful function. Few applications for new facilities are turned down, and the need for this additional bureaucracy has been eliminated by the onset of prospective reimbursement. The amendment, as adopted, preserves the useful information gathering functions of the ESRD Networks while eliminating the unneeded expense and bureaucracy.

Though I share with my Republican colleagues some of their doubts about the expense of this bill, and the impractibility of the Budget Committee's instructions, on balance I believe that H.R. 4136 makes productive changes in the Medicare and Medicaid programs, and I urge my colleagues to support it.

TOM BLILEY.

MINORITY VIEWS ON H.R. 4136—MEDICARE AND MEDICAID BUDGET RECONCILIATION AMENDMENTS OF 1983

We feel compelled to register our strong opposition to H.R. 4136 as reported by the Energy and Commerce Committee.

It is clear to us and ought to be apparent to anyone who reviews H.R. 4136 that the Committee has failed to meet the instructions of the Conference Report on the First Concurrent Budget Resolution. The reason for this is two-fold. One, the Committee was given unrealistic instructions and, therefore, unattainable savings targets. Secondly, and more importantly, the provisions of H.R. 4136 will result in a reduction in reimbursable services under Medicare. Thus, the minimal savings achieved will most likely be loaded onto the backs of the beneficiaries—our nation's elderly. For these reasons, we voted against reporting H.R. 4136 and, unlike our Democratic colleagues, oppose this bill.

The Conference Report on H. Con. Res. 91, the First Concurrent Resolution on the Budget, calls for three-year savings of $1.7 billion from programs within our Committee's jurisdiction, and a three-year increase of $950 million for a "maternal and child health initative" under Medicaid. The Conference Report specifically states that none of the savings achieved under Medicare can result in either increased costs or service reductions to the beneficiaries.

In conflict with the instructions, H.R. 4136 results in savings under Medicare of only $450 million, not the mandated $1.7 billion over three years. In addition, with respect to Medicaid, H.R. 4136 will cost at least $1.3 billion, although we were instructed to expand entitlement expenditures by only $950 million. The net result of this bill is to increase costs by a total of $850 million. This amount may well be much higher due to the many amendments

adopted, the cost of which have not been estimated as yet. H.R. 4136 is not only a budget buster, but it achieves a minimal level of savings at the expense of Medicare beneficiaries.

For the benefit of our colleagues in the House, we want to briefly decribe the Medicare savings in the bill which will be quite harmful to beneficiaries. Two provisions represent a direct reduction in currently reimbursable services: one establishes guidelines on the allowable frequency of pacemaker monitoring, and the second limits payment to physicians trimming mycotic toenails to no more than once every sixty days. Both of these changes in Medicare services would more appropriately be made through regulation by the Health Care Financing Administration.

Another Medicare provision creates a national fee schedule for out-patient laboratory tests. Only hospitals and independent laboratories would be required to accept "assignment" and receive the full laboratory fee. Physicians would not have to accept "assignment", but would receive only 80 percent of the laboratory fee. In testimony before our Committee, government and other experts stated that reductions in physician reimbursment under Medicare would most likely be shifted to be beneficiary.

Of all the provisions in H.R. 4136, these three provisions are the only ones which achieve Medicare savings. The remaining Medicare amendments call for studies, the mailing of physician lists to beneficiaries, and an expansion of the Medicare program for End Stage Renal Disease patients. These provisions will increase Medicare program costs, so that total savings under Medicare would barely equal one-fourth of the $1.7 billion requested of the Committee.

On the other hand, the Subcommittee bill meets the Medicaid spending instructions by expanding the already out-of-control Medicaid entitlement. This program would allow States to extend coverage to certain groups of pregnant women and infants with 100 percent Federal matching payments. In addition, two amendments adopted at Committee markup increased Medicaid spending by $173 million for three years. One is an addition of funds under Medicaid to Puerto Rico and the Territories, and the other would eliminate any co-payment for prescription drugs reimbursed under Medicaid.

In total, H.R. 4136 saves a grand total of $450 million, but increases spending by over $1.3 billion. The bill's net effect is to increase spending by $850 million.

In conclusion, the bill our colleagues voted to report to the House falls far short of meeting the reconciliation instructions of the Budget Resolution. It significantly expands the Medicaid program, creating new entitlement categories, while at the same time reducing services and shifting the costs to our country's sick and elderly.

Therefore, we must oppose this disingenuous piece of legislation. Not only have the Majority Members of the Committee who crafted this legislation failed to comply with the Budget Resolution, they have imposed an additional hardship upon the elderly of this country without providing any meaningful reforms to the system.

JAMES T. BROYHILL.
N. F. LENT.
CARLOS J. MOORHEAD.
TOM CORCORAN.
BILL DANNEMEYER.
THOMAS J. TAUKE.
DAN COATS.
JACK FIELDS.
MICHAEL G. OXLEY.
HOWARD C. NIELSON.

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